

SENATE
STATE OF MINNESOTA
NINETIETH SESSION

S.F. No. 800

(SENATE AUTHORS: BENSON and Abeler)

DATE	D-PG	OFFICIAL STATUS
02/09/2017	554	Introduction and first reading Referred to Health and Human Services Finance and Policy
03/27/2017	1966	Author added Abeler
03/28/2017	2190a	Comm report: To pass as amended and re-refer to Finance
03/29/2017	2631a	Comm report: To pass as amended
	2639	Second reading
04/03/2017	3088a	Special Order: Amended
	3116	Third reading Passed
04/18/2017	3161	Returned from House with amendment
	3162	Senate not concur, conference committee of 5 requested
	3170	Senate conferees Benson; Abeler; Housley; Utke; Lourey
04/20/2017	3183	House conferees Dean, M.; Schomacker; Albright; Kiel; Schultz
05/09/2017	3571c	Conference committee report, delete everything Senate adopted CC report and repassed bill
	4050	Third reading
	4292	House adopted SCC report and repassed bill Presentment date 05/09/17 Governor's action Veto 05/12/17 Secretary of State Chapter 45 05/12/17
05/15/2017	4524	Veto message laid on table

1.1 A bill for an act

1.2 relating to state government; establishing the health and human services budget;

1.3 modifying provisions governing community supports, housing, continuing care,

1.4 health care, health insurance, direct care and treatment, children and families,

1.5 chemical and mental health services, Department of Human Services operations,

1.6 Health Department, health licensing boards, and opiate abuse prevention; making

1.7 technical changes; modifying terminology and definitions; establishing licensing

1.8 fix-it tickets; establishing federally facilitated marketplace; requiring legislative

1.9 approval for certain federal waivers and approval; repealing MNsure; requiring

1.10 reports; modifying fees; making forecast adjustments; appropriating money;

1.11 amending Minnesota Statutes 2016, sections 3.972, by adding subdivisions; 13.32,

1.12 by adding a subdivision; 13.46, subdivisions 1, 2; 13.69, subdivision 1; 13.84,

1.13 subdivision 5; 62A.04, subdivision 1; 62A.21, subdivision 2a; 62A.3075; 62D.105;

1.14 62E.04, subdivision 11; 62E.05, subdivision 1; 62E.06, by adding a subdivision;

1.15 62K.15; 103I.101, subdivisions 2, 5; 103I.111, subdivisions 6, 7, 8; 103I.205;

1.16 103I.301; 103I.501; 103I.505; 103I.515; 103I.535, subdivisions 3, 6, by adding a

1.17 subdivision; 103I.541; 103I.545, subdivisions 1, 2; 103I.711, subdivision 1;

1.18 103I.715, subdivision 2; 119B.13, subdivision 1; 144.0722, subdivision 1; 144.0724,

1.19 subdivisions 1, 2, 4, 6, 9; 144.122; 144.1501, subdivision 2; 144.1506; 144.551,

1.20 subdivision 1; 144.562, subdivision 2; 144.99, subdivision 1; 144A.071,

1.21 subdivisions 3, 4a, 4c, 4d; 144A.073, subdivision 3c; 144A.10, subdivision 4;

1.22 144A.15, subdivision 2; 144A.154; 144A.161, subdivision 10; 144A.1888;

1.23 144A.351, subdivision 1; 144A.472, subdivision 7; 144A.474, subdivision 11;

1.24 144A.4799, subdivision 3; 144A.611, subdivision 1; 144A.70, subdivision 6, by

1.25 adding a subdivision; 144A.74; 144D.04, subdivision 2, by adding a subdivision;

1.26 144D.06; 145.4131, subdivision 1; 145.4716, subdivision 2; 145.928, subdivision

1.27 13; 145.986, subdivision 1a; 147.01, subdivision 7; 147.02, subdivision 1; 147.03,

1.28 subdivision 1; 147B.08, by adding a subdivision; 147C.40, by adding a subdivision;

1.29 148.5194, subdivision 7; 148.6402, subdivision 4; 148.6405; 148.6408, subdivision

1.30 2; 148.6410, subdivision 2; 148.6412, subdivision 2; 148.6415; 148.6418,

1.31 subdivisions 1, 2, 4, 5; 148.6420, subdivisions 1, 3, 5; 148.6423; 148.6425,

1.32 subdivisions 2, 3; 148.6428; 148.6443, subdivisions 5, 6, 7, 8; 148.6445,

1.33 subdivisions 1, 10; 148.6448; 148.881; 148.89; 148.90, subdivisions 1, 2; 148.905,

1.34 subdivision 1; 148.907, subdivisions 1, 2; 148.9105, subdivisions 1, 4, 5; 148.916,

1.35 subdivisions 1, 1a; 148.925; 148.96, subdivision 3; 148B.53, subdivision 1;

1.36 150A.06, subdivisions 3, 8; 150A.10, subdivision 4; 151.212, subdivision 2; 152.11,

1.37 by adding a subdivision; 152.25, subdivision 1, by adding subdivisions; 152.33,

1.38 by adding a subdivision; 157.16, subdivision 1; 214.01, subdivision 2; 245.4889,

1.39 subdivision 1; 245.814, subdivisions 2, 3; 245.91, subdivisions 4, 6; 245.94,

2.1 subdivision 1; 245.97, subdivision 6; 245A.02, subdivisions 2b, 5a, by adding
 2.2 subdivisions; 245A.03, subdivisions 2, 7; 245A.04, subdivisions 4, 14; 245A.06,
 2.3 subdivisions 2, 8, by adding a subdivision; 245A.07, subdivision 3; 245A.11, by
 2.4 adding subdivisions; 245A.191; 245A.50, subdivision 5; 245D.03, subdivision 1;
 2.5 245D.04, subdivision 3; 245D.071, subdivision 3; 245D.11, subdivision 4; 245D.24,
 2.6 subdivision 3; 246.18, subdivision 4, by adding a subdivision; 252.27, subdivision
 2.7 2a; 252.41, subdivision 3; 253B.10, subdivision 1; 253B.22, subdivision 1;
 2.8 254A.01; 254A.02, subdivisions 2, 3, 5, 6, 8, 10, by adding subdivisions; 254A.03;
 2.9 254A.035, subdivision 1; 254A.04; 254A.08; 254A.09; 254A.19, subdivision 3;
 2.10 254B.01, subdivision 3, by adding a subdivision; 254B.03, subdivision 2; 254B.04,
 2.11 subdivisions 1, 2b; 254B.05, subdivisions 1, 1a, 5; 254B.051; 254B.07; 254B.08;
 2.12 254B.09; 254B.12, subdivision 2, by adding a subdivision; 254B.13, subdivision
 2.13 2a; 256.045, subdivision 3; 256.9657, subdivision 1; 256.9686, subdivision 8;
 2.14 256.969, subdivisions 1, 2b, 3a, 8, 8c, 9, 12; 256.975, subdivision 7, by adding a
 2.15 subdivision; 256B.04, subdivision 12; 256B.056, subdivision 5c; 256B.0621,
 2.16 subdivision 10; 256B.0625, subdivisions 3b, 6a, 7, 13, 13e, 17, 17b, 18h, 20, 30,
 2.17 31, 45a, 64, by adding subdivisions; 256B.0653, subdivisions 2, 3, 4, 5, 6, by
 2.18 adding a subdivision; 256B.0659, subdivisions 1, 2, 11, 21, by adding a subdivision;
 2.19 256B.072; 256B.0755, subdivisions 1, 3, 4, by adding a subdivision; 256B.0911,
 2.20 subdivisions 1a, 2b, 3a, 4d, 5, by adding a subdivision; 256B.0915, subdivisions
 2.21 1, 3a, 3e, 3h, 5, by adding subdivisions; 256B.092, subdivision 4; 256B.0921;
 2.22 256B.0922, subdivision 1; 256B.0924, by adding a subdivision; 256B.0943,
 2.23 subdivision 13; 256B.0945, subdivisions 2, 4; 256B.196, subdivisions 2, 3, 4;
 2.24 256B.35, subdivision 4; 256B.431, subdivisions 10, 16, 30; 256B.434, subdivisions
 2.25 4, 4f; 256B.49, subdivisions 11, 15; 256B.4913, subdivision 4a, by adding a
 2.26 subdivision; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 16; 256B.493,
 2.27 subdivisions 1, 2, by adding a subdivision; 256B.50, subdivisions 1, 1b; 256B.5012,
 2.28 by adding subdivisions; 256B.69, subdivisions 5a, 9e, by adding a subdivision;
 2.29 256B.75; 256B.763; 256B.766; 256C.23, subdivision 2, by adding subdivisions;
 2.30 256C.233, subdivisions 1, 2; 256C.24, subdivisions 1, 2; 256C.261; 256D.44,
 2.31 subdivisions 4, 5; 256E.30, subdivision 2; 256I.03, subdivision 8; 256I.04,
 2.32 subdivisions 1, 2d, 2g, 3; 256I.05, subdivisions 1a, 1c, 1e, 1j, 1m, by adding
 2.33 subdivisions; 256I.06, subdivisions 2, 8; 256J.24, subdivision 5; 256J.45,
 2.34 subdivision 2; 256P.06, subdivision 2; 256R.02, subdivisions 4, 17, 18, 19, 22,
 2.35 42, 52, by adding subdivisions; 256R.06, subdivision 5; 256R.07, by adding a
 2.36 subdivision; 256R.10, by adding a subdivision; 256R.37; 256R.40, subdivisions
 2.37 1, 5; 256R.41; 256R.47; 256R.49, subdivision 1; 256R.53, subdivision 2; 260C.451,
 2.38 subdivision 6; 317A.811, subdivision 1, by adding a subdivision; 327.15,
 2.39 subdivision 3; 609.5315, subdivision 5c; 626.556, subdivisions 2, 3, 3c, 10d; Laws
 2.40 2009, chapter 101, article 1, section 12; Laws 2012, chapter 247, article 6, section
 2.41 2, subdivision 2; Laws 2013, chapter 108, article 15, section 2, subdivision 2; Laws
 2.42 2015, chapter 71, article 14, section 3, subdivision 2, as amended; Laws 2017,
 2.43 chapter 2, article 1, sections 5; 7; proposing coding for new law in Minnesota
 2.44 Statutes, chapters 62J; 119B; 144; 145; 147A; 148; 245; 245A; 256; 256B; 256I;
 2.45 256N; 256R; 317A; proposing coding for new law as Minnesota Statutes, chapters
 2.46 144H; 245G; repealing Minnesota Statutes 2016, sections 13.468; 62V.01; 62V.02;
 2.47 62V.03; 62V.04; 62V.05; 62V.051; 62V.055; 62V.06; 62V.07; 62V.08; 62V.09;
 2.48 62V.10; 62V.11; 144.4961; 144A.351, subdivision 2; 147.0375, subdivision 7;
 2.49 147A.21; 147B.08, subdivisions 1, 2, 3; 147C.40, subdivisions 1, 2, 3, 4; 148.6402,
 2.50 subdivision 2; 148.6450; 148.906; 148.907, subdivision 5; 148.908; 148.909,
 2.51 subdivision 7; 148.96, subdivisions 4, 5; 179A.50; 179A.51; 179A.52; 179A.53;
 2.52 245A.1915; 245A.192; 254A.02, subdivision 4; 256B.4914, subdivision 16;
 2.53 256B.64; 256B.7631; 256C.23, subdivision 3; 256C.233, subdivision 4; 256C.25,
 2.54 subdivisions 1, 2; 256J.626, subdivision 5; Laws 2012, chapter 247, article 4,
 2.55 section 47, as amended; Laws 2014, chapter 312, article 23, section 9, subdivision
 2.56 5; Laws 2015, chapter 71, article 7, section 54; Minnesota Rules, parts 5600.2500;
 2.57 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a,
 2.58 16, 17, 17a, 17b, 17c, 18, 20, 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422;

3.1 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455;
 3.2 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490;
 3.3 9530.6495; 9530.6500; 9530.6505.

3.4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

3.5 **ARTICLE 1**

3.6 **COMMUNITY SUPPORTS**

3.7 Section 1. Minnesota Statutes 2016, section 144A.351, subdivision 1, is amended to read:

3.8 Subdivision 1. **Report requirements.** The commissioners of health and human services,
 3.9 with the cooperation of counties and in consultation with stakeholders, including persons
 3.10 who need or are using long-term care services and supports, lead agencies, regional entities,
 3.11 senior, disability, and mental health organization representatives, service providers, and
 3.12 community members shall prepare a report to the legislature by August 15, 2013, and
 3.13 biennially thereafter, regarding the status of the full range of long-term care services and
 3.14 supports for the elderly and children and adults with disabilities and mental illnesses in
 3.15 Minnesota. Any amounts appropriated for this report are available in either year of the
 3.16 biennium. The report shall address:

3.17 (1) demographics and need for long-term care services and supports in Minnesota;

3.18 (2) summary of county and regional reports on long-term care gaps, surpluses, imbalances,
 3.19 and corrective action plans;

3.20 (3) status of long-term care services and related mental health services, housing options,
 3.21 and supports by county and region including:

3.22 (i) changes in availability of the range of long-term care services and housing options;

3.23 (ii) access problems, including access to the least restrictive and most integrated services
 3.24 and settings, regarding long-term care services; and

3.25 (iii) comparative measures of long-term care services availability, including serving
 3.26 people in their home areas near family, and changes over time; and

3.27 (4) recommendations regarding goals for the future of long-term care services and
 3.28 supports, policy and fiscal changes, and resource development and transition needs.

3.29 Sec. 2. Minnesota Statutes 2016, section 245D.03, subdivision 1, is amended to read:

3.30 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home
 3.31 and community-based services to persons with disabilities and persons age 65 and older

4.1 pursuant to this chapter. The licensing standards in this chapter govern the provision of
 4.2 basic support services and intensive support services.

4.3 (b) Basic support services provide the level of assistance, supervision, and care that is
 4.4 necessary to ensure the health and welfare of the person and do not include services that
 4.5 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
 4.6 person. Basic support services include:

4.7 (1) in-home and out-of-home respite care services as defined in section 245A.02,
 4.8 subdivision 15, and under the brain injury, community alternative care, community access
 4.9 for disability inclusion, developmental disability, and elderly waiver plans, excluding
 4.10 out-of-home respite care provided to children in a family child foster care home licensed
 4.11 under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license
 4.12 holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8,
 4.13 or successor provisions; and section 245D.061 or successor provisions, which must be
 4.14 stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000,
 4.15 subpart 4;

4.16 (2) adult companion services as defined under the brain injury, community access for
 4.17 disability inclusion, and elderly waiver plans, excluding adult companion services provided
 4.18 under the Corporation for National and Community Services Senior Companion Program
 4.19 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

4.20 (3) personal support as defined under the developmental disability waiver plan;

4.21 (4) 24-hour emergency assistance, personal emergency response as defined under the
 4.22 community access for disability inclusion and developmental disability waiver plans;

4.23 (5) night supervision services as defined under the brain injury waiver plan; ~~and~~

4.24 (6) homemaker services as defined under the community access for disability inclusion,
 4.25 brain injury, community alternative care, developmental disability, and elderly waiver plans,
 4.26 excluding providers licensed by the Department of Health under chapter 144A and those
 4.27 providers providing cleaning services only; and

4.28 (7) individual community living support under section 256B.0915, subdivision 3j.

4.29 (c) Intensive support services provide assistance, supervision, and care that is necessary
 4.30 to ensure the health and welfare of the person and services specifically directed toward the
 4.31 training, habilitation, or rehabilitation of the person. Intensive support services include:

4.32 (1) intervention services, including:

5.1 (i) behavioral support services as defined under the brain injury and community access
5.2 for disability inclusion waiver plans;

5.3 (ii) in-home or out-of-home crisis respite services as defined under the developmental
5.4 disability waiver plan; and

5.5 (iii) specialist services as defined under the current developmental disability waiver
5.6 plan;

5.7 (2) in-home support services, including:

5.8 (i) in-home family support and supported living services as defined under the
5.9 developmental disability waiver plan;

5.10 (ii) independent living services training as defined under the brain injury and community
5.11 access for disability inclusion waiver plans; ~~and~~

5.12 (iii) semi-independent living services; and

5.13 (iv) individualized home supports services as defined under the brain injury, community
5.14 alternative care, and community access for disability inclusion waiver plans;

5.15 (3) residential supports and services, including:

5.16 (i) supported living services as defined under the developmental disability waiver plan
5.17 provided in a family or corporate child foster care residence, a family adult foster care
5.18 residence, a community residential setting, or a supervised living facility;

5.19 (ii) foster care services as defined in the brain injury, community alternative care, and
5.20 community access for disability inclusion waiver plans provided in a family or corporate
5.21 child foster care residence, a family adult foster care residence, or a community residential
5.22 setting; and

5.23 (iii) residential services provided to more than four persons with developmental
5.24 disabilities in a supervised living facility, including ICFs/DD;

5.25 (4) day services, including:

5.26 (i) structured day services as defined under the brain injury waiver plan;

5.27 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined
5.28 under the developmental disability waiver plan; and

5.29 (iii) prevocational services as defined under the brain injury and community access for
5.30 disability inclusion waiver plans; and

6.1 (5) ~~supported employment as defined under the brain injury, developmental disability,~~
 6.2 ~~and community access for disability inclusion waiver plans~~ employment exploration services
 6.3 as defined under the brain injury, community alternative care, community access for disability
 6.4 inclusion, and developmental disability waiver plans;

6.5 (6) employment development services as defined under the brain injury, community
 6.6 alternative care, community access for disability inclusion, and developmental disability
 6.7 waiver plans; and

6.8 (7) employment support services as defined under the brain injury, community alternative
 6.9 care, community access for disability inclusion, and developmental disability waiver plans.

6.10 **EFFECTIVE DATE.** (a) The amendment to paragraphs (b) and (c), clause (2), is
 6.11 effective the day following final enactment.

6.12 (b) The amendments to paragraph (c), clauses (5) to (7), are effective upon federal
 6.13 approval. The commissioner of human services shall notify the revisor of statutes when
 6.14 federal approval is obtained.

6.15 Sec. 3. Minnesota Statutes 2016, section 252.41, subdivision 3, is amended to read:

6.16 Subd. 3. **Day training and habilitation services for adults with developmental**
 6.17 **disabilities.** (a) "Day training and habilitation services for adults with developmental
 6.18 disabilities" means services that:

6.19 (1) include supervision, training, assistance, ~~and supported employment,~~ center-based
 6.20 work-related activities, or other community-integrated activities designed and implemented
 6.21 in accordance with the individual service and individual habilitation plans required under
 6.22 Minnesota Rules, parts 9525.0004 to 9525.0036, to help an adult reach and maintain the
 6.23 highest possible level of independence, productivity, and integration into the community;
 6.24 and

6.25 (2) are provided by a vendor licensed under sections 245A.01 to 245A.16 and 252.28,
 6.26 subdivision 2, to provide day training and habilitation services.

6.27 (b) Day training and habilitation services reimbursable under this section do not include
 6.28 special education and related services as defined in the Education of the Individuals with
 6.29 Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17),
 6.30 or vocational services funded under section 110 of the Rehabilitation Act of 1973, United
 6.31 States Code, title 29, section 720, as amended.

7.1 (c) Day training and habilitation services do not include employment exploration,
 7.2 employment development, or employment support services as defined in the home and
 7.3 community-based services waivers for people with disabilities authorized under sections
 7.4 256B.092 and 256B.49.

7.5 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 7.6 of human services shall notify the revisor of statutes when federal approval is obtained.

7.7 **Sec. 4. [256.477] SELF-ADVOCACY GRANTS.**

7.8 (a) The commissioner shall make available a grant for the purposes of establishing and
 7.9 maintaining a statewide self-advocacy network for persons with intellectual and
 7.10 developmental disabilities. The self-advocacy network shall:

7.11 (1) ensure that persons with intellectual and developmental disabilities are informed of
 7.12 their rights in employment, housing, transportation, voting, government policy, and other
 7.13 issues pertinent to the intellectual and developmental disability community;

7.14 (2) provide public education and awareness of the civil and human rights issues persons
 7.15 with intellectual and developmental disabilities face;

7.16 (3) provide funds, technical assistance, and other resources for self-advocacy groups
 7.17 across the state; and

7.18 (4) organize systems of communications to facilitate an exchange of information between
 7.19 self-advocacy groups.

7.20 (b) An organization receiving a grant under paragraph (a) must be an organization
 7.21 governed by people with intellectual and developmental disabilities that administers a
 7.22 statewide network of disability groups in order to maintain and promote self-advocacy
 7.23 services and supports for persons with intellectual and developmental disabilities throughout
 7.24 the state.

7.25 **Sec. 5. Minnesota Statutes 2016, section 256B.0625, subdivision 6a, is amended to read:**

7.26 **Subd. 6a. Home health services.** Home health services are those services specified in
 7.27 Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance
 7.28 covers home health services at a recipient's home residence or in the community where
 7.29 normal life activities take the recipient. Medical assistance does not cover home health
 7.30 services for residents of a hospital, nursing facility, or intermediate care facility, unless the
 7.31 commissioner of human services has authorized skilled nurse visits for less than 90 days
 7.32 for a resident at an intermediate care facility for persons with developmental disabilities,

8.1 to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise
8.2 eligible is on leave from the facility and the facility either pays for the home health services
8.3 or forgoes the facility per diem for the leave days that home health services are used. Home
8.4 health services must be provided by a Medicare certified home health agency. All nursing
8.5 and home health aide services must be provided according to sections 256B.0651 to
8.6 256B.0653.

8.7 Sec. 6. Minnesota Statutes 2016, section 256B.0625, subdivision 31, is amended to read:

8.8 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
8.9 supplies and equipment. Separate payment outside of the facility's payment rate shall be
8.10 made for wheelchairs and wheelchair accessories for recipients who are residents of
8.11 intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs
8.12 and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions
8.13 and limitations as coverage for recipients who do not reside in institutions. A wheelchair
8.14 purchased outside of the facility's payment rate is the property of the recipient.

8.15 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
8.16 must enroll as a Medicare provider.

8.17 (c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics,
8.18 or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment
8.19 requirement if:

8.20 (1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic,
8.21 or medical supply;

8.22 (2) the vendor serves ten or fewer medical assistance recipients per year;

8.23 (3) the commissioner finds that other vendors are not available to provide same or similar
8.24 durable medical equipment, prosthetics, orthotics, or medical supplies; and

8.25 (4) the vendor complies with all screening requirements in this chapter and Code of
8.26 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
8.27 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
8.28 and Medicaid Services approved national accreditation organization as complying with the
8.29 Medicare program's supplier and quality standards and the vendor serves primarily pediatric
8.30 patients.

8.31 (d) Durable medical equipment means a device or equipment that:

8.32 (1) can withstand repeated use;

9.1 (2) is generally not useful in the absence of an illness, injury, or disability; and

9.2 (3) is provided to correct or accommodate a physiological disorder or physical condition
9.3 or is generally used primarily for a medical purpose.

9.4 (e) Electronic tablets may be considered durable medical equipment if the electronic
9.5 tablet will be used as an augmentative and alternative communication system as defined
9.6 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must
9.7 be locked in order to prevent use not related to communication.

9.8 (f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be
9.9 locked to prevent use not as an augmentative communication device, a recipient of waiver
9.10 services may use an electronic tablet for a use not related to communication when the
9.11 recipient has been authorized under the waiver to receive one or more additional applications
9.12 that can be loaded onto the electronic tablet, such that allowing the additional use prevents
9.13 the purchase of a separate electronic tablet with waiver funds.

9.14 (g) An order or prescription for medical supplies, equipment, or appliances must meet
9.15 the requirements in Code of Federal Regulations, title 42, part 470.

9.16 Sec. 7. Minnesota Statutes 2016, section 256B.0653, subdivision 2, is amended to read:

9.17 Subd. 2. **Definitions.** For the purposes of this section, the following terms have the
9.18 meanings given.

9.19 (a) "Assessment" means an evaluation of the recipient's medical need for home health
9.20 agency services by a registered nurse or appropriate therapist that is conducted within 30
9.21 days of a request.

9.22 (b) "Home care therapies" means occupational, physical, and respiratory therapy and
9.23 speech-language pathology services provided in the home by a Medicare certified home
9.24 health agency.

9.25 (c) "Home health agency services" means services delivered ~~in the recipient's home~~
9.26 ~~residence, except as specified in section 256B.0625,~~ by a home health agency to a recipient
9.27 with medical needs due to illness, disability, or physical conditions in settings permitted
9.28 under section 256B.0625, subdivision 6a.

9.29 (d) "Home health aide" means an employee of a home health agency who completes
9.30 medically oriented tasks written in the plan of care for a recipient.

9.31 (e) "Home health agency" means a home care provider agency that is Medicare-certified.

10.1 (f) "Occupational therapy services" mean the services defined in Minnesota Rules, part
10.2 9505.0390.

10.3 (g) "Physical therapy services" mean the services defined in Minnesota Rules, part
10.4 9505.0390.

10.5 (h) "Respiratory therapy services" mean the services defined in chapter 147C.

10.6 (i) "Speech-language pathology services" mean the services defined in Minnesota Rules,
10.7 part 9505.0390.

10.8 (j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks
10.9 required due to a recipient's medical condition that can only be safely provided by a
10.10 professional nurse to restore and maintain optimal health.

10.11 (k) "Store-and-forward technology" means telehomecare services that do not occur in
10.12 real time via synchronous transmissions such as diabetic and vital sign monitoring.

10.13 (l) "Telehomecare" means the use of telecommunications technology via live, two-way
10.14 interactive audiovisual technology which may be augmented by store-and-forward
10.15 technology.

10.16 (m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to deliver
10.17 a skilled nurse visit to a recipient located at a site other than the site where the nurse is
10.18 located and is used in combination with face-to-face skilled nurse visits to adequately meet
10.19 the recipient's needs.

10.20 Sec. 8. Minnesota Statutes 2016, section 256B.0653, subdivision 3, is amended to read:

10.21 Subd. 3. **Home health aide visits.** (a) Home health aide visits must be provided by a
10.22 certified home health aide using a written plan of care that is updated in compliance with
10.23 Medicare regulations. A home health aide shall provide hands-on personal care, perform
10.24 simple procedures as an extension of therapy or nursing services, and assist in instrumental
10.25 activities of daily living as defined in section 256B.0659, including assuring that the person
10.26 gets to medical appointments if identified in the written plan of care. Home health aide
10.27 visits ~~must~~ may be provided in the recipient's home or in the community where normal life
10.28 activities take the recipient.

10.29 (b) All home health aide visits must have authorization under section 256B.0652. The
10.30 commissioner shall limit home health aide visits to no more than one visit per day per
10.31 recipient.

11.1 (c) Home health aides must be supervised by a registered nurse or an appropriate therapist
11.2 when providing services that are an extension of therapy.

11.3 Sec. 9. Minnesota Statutes 2016, section 256B.0653, subdivision 4, is amended to read:

11.4 Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be provided
11.5 by a registered nurse or a licensed practical nurse under the supervision of a registered nurse,
11.6 according to the written plan of care and accepted standards of medical and nursing practice
11.7 according to chapter 148. Skilled nurse visit services must be ordered by a physician and
11.8 documented in a plan of care that is reviewed and approved by the ordering physician at
11.9 least once every 60 days. All skilled nurse visits must be medically necessary and provided
11.10 in the recipient's home residence or in the community where normal life activities take the
11.11 recipient, except as allowed under section 256B.0625, subdivision 6a.

11.12 (b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of up
11.13 to two visits per day per recipient. All visits must be based on assessed needs.

11.14 (c) Telehomecare skilled nurse visits are allowed when the recipient's health status can
11.15 be accurately measured and assessed without a need for a face-to-face, hands-on encounter.
11.16 All telehomecare skilled nurse visits must have authorization and are paid at the same
11.17 allowable rates as face-to-face skilled nurse visits.

11.18 (d) The provision of telehomecare must be made via live, two-way interactive audiovisual
11.19 technology and may be augmented by utilizing store-and-forward technologies. Individually
11.20 identifiable patient data obtained through real-time or store-and-forward technology must
11.21 be maintained as health records according to sections 144.291 to 144.298. If the video is
11.22 used for research, training, or other purposes unrelated to the care of the patient, the identity
11.23 of the patient must be concealed.

11.24 (e) Authorization for skilled nurse visits must be completed under section 256B.0652.
11.25 A total of nine face-to-face skilled nurse visits per calendar year do not require authorization.
11.26 All telehomecare skilled nurse visits require authorization.

11.27 Sec. 10. Minnesota Statutes 2016, section 256B.0653, subdivision 5, is amended to read:

11.28 Subd. 5. **Home care therapies.** (a) Home care therapies include the following: physical
11.29 therapy, occupational therapy, respiratory therapy, and speech and language pathology
11.30 therapy services.

11.31 (b) Home care therapies must be:

12.1 (1) provided in the recipient's residence or in the community where normal life activities
12.2 take the recipient after it has been determined the recipient is unable to access outpatient
12.3 therapy;

12.4 (2) prescribed, ordered, or referred by a physician and documented in a plan of care and
12.5 reviewed, according to Minnesota Rules, part 9505.0390;

12.6 (3) assessed by an appropriate therapist; and

12.7 (4) provided by a Medicare-certified home health agency enrolled as a Medicaid provider
12.8 agency.

12.9 (c) Restorative and specialized maintenance therapies must be provided according to
12.10 Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be used
12.11 as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

12.12 (d) For both physical and occupational therapies, the therapist and the therapist's assistant
12.13 may not both bill for services provided to a recipient on the same day.

12.14 Sec. 11. Minnesota Statutes 2016, section 256B.0653, subdivision 6, is amended to read:

12.15 Subd. 6. **Noncovered home health agency services.** The following are not eligible for
12.16 payment under medical assistance as a home health agency service:

12.17 (1) telehomecare skilled nurses services that is communication between the home care
12.18 nurse and recipient that consists solely of a telephone conversation, facsimile, electronic
12.19 mail, or a consultation between two health care practitioners;

12.20 (2) the following skilled nurse visits:

12.21 (i) for the purpose of monitoring medication compliance with an established medication
12.22 program for a recipient;

12.23 (ii) administering or assisting with medication administration, including injections,
12.24 prefilling syringes for injections, or oral medication setup of an adult recipient, when, as
12.25 determined and documented by the registered nurse, the need can be met by an available
12.26 pharmacy or the recipient or a family member is physically and mentally able to
12.27 self-administer or prefill a medication;

12.28 (iii) services done for the sole purpose of supervision of the home health aide or personal
12.29 care assistant;

12.30 (iv) services done for the sole purpose to train other home health agency workers;

13.1 (v) services done for the sole purpose of blood samples or lab draw when the recipient
13.2 is able to access these services outside the home; and

13.3 (vi) Medicare evaluation or administrative nursing visits required by Medicare;

13.4 (3) home health aide visits when the following activities are the sole purpose for the
13.5 visit: companionship, socialization, household tasks, transportation, and education; ~~and~~

13.6 (4) home care therapies provided in other settings such as a clinic, ~~day program~~, or as
13.7 an inpatient or when the recipient can access therapy outside of the recipient's residence;
13.8 and

13.9 (5) home health agency services without qualifying documentation of a face-to-face
13.10 encounter as specified in subdivision 7.

13.11 Sec. 12. Minnesota Statutes 2016, section 256B.0653, is amended by adding a subdivision
13.12 to read:

13.13 Subd. 7. **Face-to-face encounter.** (a) A face-to-face encounter by a qualifying provider
13.14 must be completed for all home health services regardless of the need for prior authorization,
13.15 except when providing a onetime perinatal visit by skilled nursing. The face-to-face encounter
13.16 may occur through telemedicine as defined in section 256B.0625, subdivision 3b. The
13.17 encounter must be related to the primary reason the recipient requires home health services
13.18 and must occur within the 90 days before or the 30 days after the start of services. The
13.19 face-to-face encounter may be conducted by one of the following practitioners, licensed in
13.20 Minnesota:

13.21 (1) a physician;

13.22 (2) a nurse practitioner or clinical nurse specialist;

13.23 (3) a certified nurse midwife; or

13.24 (4) a physician assistant.

13.25 (b) The allowed nonphysician practitioner, as described in this subdivision, performing
13.26 the face-to-face encounter must communicate the clinical findings of that face-to-face
13.27 encounter to the ordering physician. Those clinical findings must be incorporated into a
13.28 written or electronic document included in the recipient's medical record. To assure clinical
13.29 correlation between the face-to-face encounter and the associated home health services, the
13.30 physician responsible for ordering the services must:

13.31 (1) document that the face-to-face encounter, which is related to the primary reason the
13.32 recipient requires home health services, occurred within the required time period; and

14.1 (2) indicate the practitioner who conducted the encounter and the date of the encounter.

14.2 (c) For home health services requiring authorization, including prior authorization, home
14.3 health agencies must retain the qualifying documentation of a face-to-face encounter as part
14.4 of the recipient health service record, and submit the qualifying documentation to the
14.5 commissioner or the commissioner's designee upon request.

14.6 Sec. 13. Minnesota Statutes 2016, section 256B.0659, subdivision 1, is amended to read:

14.7 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in
14.8 paragraphs (b) to ~~(s)~~ (s) have the meanings given unless otherwise provided in text.

14.9 (b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility,
14.10 positioning, eating, and toileting.

14.11 (c) "Behavior," effective January 1, 2010, means a category to determine the home care
14.12 rating and is based on the criteria found in this section. "Level I behavior" means physical
14.13 aggression towards self, others, or destruction of property that requires the immediate
14.14 response of another person.

14.15 (d) "Complex health-related needs," effective January 1, 2010, means a category to
14.16 determine the home care rating and is based on the criteria found in this section.

14.17 (e) "Complex personal care assistance services" means personal care assistance services:

14.18 (1) for a person who qualifies for ten hours or more of personal care assistance services
14.19 per day; and

14.20 (2) provided by a personal care assistant who is qualified to provide complex personal
14.21 assistance services under subdivision 11, paragraph (d).

14.22 ~~(e)~~ (f) "Critical activities of daily living," effective January 1, 2010, means transferring,
14.23 mobility, eating, and toileting.

14.24 ~~(f)~~ (g) "Dependency in activities of daily living" means a person requires assistance to
14.25 begin and complete one or more of the activities of daily living.

14.26 ~~(g)~~ (h) "Extended personal care assistance service" means personal care assistance
14.27 services included in a service plan under one of the home and community-based services
14.28 waivers authorized under sections 256B.0915, 256B.092, subdivision 5, and 256B.49, which
14.29 exceed the amount, duration, and frequency of the state plan personal care assistance services
14.30 for participants who:

15.1 (1) need assistance provided periodically during a week, but less than daily will not be
15.2 able to remain in their homes without the assistance, and other replacement services are
15.3 more expensive or are not available when personal care assistance services are to be reduced;
15.4 or

15.5 (2) need additional personal care assistance services beyond the amount authorized by
15.6 the state plan personal care assistance assessment in order to ensure that their safety, health,
15.7 and welfare are provided for in their homes.

15.8 ~~(h)~~ (i) "Health-related procedures and tasks" means procedures and tasks that can be
15.9 delegated or assigned by a licensed health care professional under state law to be performed
15.10 by a personal care assistant.

15.11 ~~(i)~~ (j) "Instrumental activities of daily living" means activities to include meal planning
15.12 and preparation; basic assistance with paying bills; shopping for food, clothing, and other
15.13 essential items; performing household tasks integral to the personal care assistance services;
15.14 communication by telephone and other media; and traveling, including to medical
15.15 appointments and to participate in the community.

15.16 ~~(j)~~ (k) "Managing employee" has the same definition as Code of Federal Regulations,
15.17 title 42, section 455.

15.18 ~~(k)~~ (l) "Qualified professional" means a professional providing supervision of personal
15.19 care assistance services and staff as defined in section 256B.0625, subdivision 19c.

15.20 ~~(l)~~ (m) "Personal care assistance provider agency" means a medical assistance enrolled
15.21 provider that provides or assists with providing personal care assistance services and includes
15.22 a personal care assistance provider organization, personal care assistance choice agency,
15.23 class A licensed nursing agency, and Medicare-certified home health agency.

15.24 ~~(m)~~ (n) "Personal care assistant" or "PCA" means an individual employed by a personal
15.25 care assistance agency who provides personal care assistance services.

15.26 ~~(n)~~ (o) "Personal care assistance care plan" means a written description of personal care
15.27 assistance services developed by the personal care assistance provider according to the
15.28 service plan.

15.29 ~~(o)~~ (p) "Responsible party" means an individual who is capable of providing the support
15.30 necessary to assist the recipient to live in the community.

15.31 ~~(p)~~ (q) "Self-administered medication" means medication taken orally, by injection,
15.32 nebulizer, or insertion, or applied topically without the need for assistance.

16.1 ~~(q)~~ (r) "Service plan" means a written summary of the assessment and description of the
 16.2 services needed by the recipient.

16.3 ~~(t)~~ (s) "Wages and benefits" means wages and salaries, the employer's share of FICA
 16.4 taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage
 16.5 reimbursement, health and dental insurance, life insurance, disability insurance, long-term
 16.6 care insurance, uniform allowance, and contributions to employee retirement accounts.

16.7 **EFFECTIVE DATE.** This section is effective July 1, 2018.

16.8 Sec. 14. Minnesota Statutes 2016, section 256B.0659, subdivision 2, is amended to read:

16.9 Subd. 2. **Personal care assistance services; covered services.** (a) The personal care
 16.10 assistance services eligible for payment include services and supports furnished to an
 16.11 individual, as needed, to assist in:

16.12 (1) activities of daily living;

16.13 (2) health-related procedures and tasks;

16.14 (3) observation and redirection of behaviors; and

16.15 (4) instrumental activities of daily living.

16.16 (b) Activities of daily living include the following covered services:

16.17 (1) dressing, including assistance with choosing, application, and changing of clothing
 16.18 and application of special appliances, wraps, or clothing;

16.19 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
 16.20 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
 16.21 except for recipients who are diabetic or have poor circulation;

16.22 (3) bathing, including assistance with basic personal hygiene and skin care;

16.23 (4) eating, including assistance with hand washing and application of orthotics required
 16.24 for eating, transfers, and feeding;

16.25 (5) transfers, including assistance with transferring the recipient from one seating or
 16.26 reclining area to another;

16.27 (6) mobility, including assistance with ambulation, including use of a wheelchair.

16.28 Mobility does not include providing transportation for a recipient;

16.29 (7) positioning, including assistance with positioning or turning a recipient for necessary
 16.30 care and comfort; and

17.1 (8) toileting, including assistance with helping recipient with bowel or bladder elimination
17.2 and care including transfers, mobility, positioning, feminine hygiene, use of toileting
17.3 equipment or supplies, cleansing the perineal area, inspection of the skin, and adjusting
17.4 clothing.

17.5 (c) Health-related procedures and tasks include the following covered services:

17.6 (1) range of motion and passive exercise to maintain a recipient's strength and muscle
17.7 functioning;

17.8 (2) assistance with self-administered medication as defined by this section, including
17.9 reminders to take medication, bringing medication to the recipient, and assistance with
17.10 opening medication under the direction of the recipient or responsible party, including
17.11 medications given through a nebulizer;

17.12 (3) interventions for seizure disorders, including monitoring and observation; and

17.13 (4) other activities considered within the scope of the personal care service and meeting
17.14 the definition of health-related procedures and tasks under this section.

17.15 (d) A personal care assistant may provide health-related procedures and tasks associated
17.16 with the complex health-related needs of a recipient if the procedures and tasks meet the
17.17 definition of health-related procedures and tasks under this section and the personal care
17.18 assistant is trained by a qualified professional and demonstrates competency to safely
17.19 complete the procedures and tasks. Delegation of health-related procedures and tasks and
17.20 all training must be documented in the personal care assistance care plan and the recipient's
17.21 and personal care assistant's files. A personal care assistant must not determine the medication
17.22 dose or time for medication.

17.23 (e) Effective January 1, 2010, for a personal care assistant to provide the health-related
17.24 procedures and tasks of tracheostomy suctioning and services to recipients on ventilator
17.25 support there must be:

17.26 (1) delegation and training by a registered nurse, certified or licensed respiratory therapist,
17.27 or a physician;

17.28 (2) utilization of clean rather than sterile procedure;

17.29 (3) specialized training about the health-related procedures and tasks and equipment,
17.30 including ventilator operation and maintenance;

17.31 (4) individualized training regarding the needs of the recipient; and

17.32 (5) supervision by a qualified professional who is a registered nurse.

18.1 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the
18.2 recipient for episodes where there is a need for redirection due to behaviors. Training of
18.3 the personal care assistant must occur based on the needs of the recipient, the personal care
18.4 assistance care plan, and any other support services provided.

18.5 (g) Instrumental activities of daily living under subdivision 1, paragraph ~~(h)~~ (j).

18.6 **EFFECTIVE DATE.** This section is effective July 1, 2018.

18.7 Sec. 15. Minnesota Statutes 2016, section 256B.0659, subdivision 11, is amended to read:

18.8 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must
18.9 meet the following requirements:

18.10 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years of
18.11 age with these additional requirements:

18.12 (i) supervision by a qualified professional every 60 days; and

18.13 (ii) employment by only one personal care assistance provider agency responsible for
18.14 compliance with current labor laws;

18.15 (2) be employed by a personal care assistance provider agency;

18.16 (3) enroll with the department as a personal care assistant after clearing a background
18.17 study. Except as provided in subdivision 11a, before a personal care assistant provides
18.18 services, the personal care assistance provider agency must initiate a background study on
18.19 the personal care assistant under chapter 245C, and the personal care assistance provider
18.20 agency must have received a notice from the commissioner that the personal care assistant
18.21 is:

18.22 (i) not disqualified under section 245C.14; or

18.23 (ii) is disqualified, but the personal care assistant has received a set aside of the
18.24 disqualification under section 245C.22;

18.25 (4) be able to effectively communicate with the recipient and personal care assistance
18.26 provider agency;

18.27 (5) be able to provide covered personal care assistance services according to the recipient's
18.28 personal care assistance care plan, respond appropriately to recipient needs, and report
18.29 changes in the recipient's condition to the supervising qualified professional or physician;

18.30 (6) not be a consumer of personal care assistance services;

19.1 (7) maintain daily written records including, but not limited to, time sheets under
19.2 subdivision 12;

19.3 (8) effective January 1, 2010, complete standardized training as determined by the
19.4 commissioner before completing enrollment. The training must be available in languages
19.5 other than English and to those who need accommodations due to disabilities. Personal care
19.6 assistant training must include successful completion of the following training components:
19.7 basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic
19.8 roles and responsibilities of personal care assistants including information about assistance
19.9 with lifting and transfers for recipients, emergency preparedness, orientation to positive
19.10 behavioral practices, fraud issues, and completion of time sheets. Upon completion of the
19.11 training components, the personal care assistant must demonstrate the competency to provide
19.12 assistance to recipients;

19.13 (9) complete training and orientation on the needs of the recipient; and

19.14 (10) be limited to providing and being paid for up to 275 hours per month of personal
19.15 care assistance services regardless of the number of recipients being served or the number
19.16 of personal care assistance provider agencies enrolled with. The number of hours worked
19.17 per day shall not be disallowed by the department unless in violation of the law.

19.18 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
19.19 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

19.20 (c) Persons who do not qualify as a personal care assistant include parents, stepparents,
19.21 and legal guardians of minors; spouses; paid legal guardians of adults; family foster care
19.22 providers, except as otherwise allowed in section 256B.0625, subdivision 19a; and staff of
19.23 a residential setting.

19.24 (d) A personal care assistant is qualified to provide complex personal care assistance
19.25 services as defined in subdivision 1, paragraph (e), if the personal care assistant:

19.26 (1) provides services according to the care plan in subdivision 7 to an individual described
19.27 in subdivision 1, paragraph (e), clause (1); and

19.28 (2) satisfies the current requirements of Medicare for training and competency or
19.29 competency evaluation of home health aides or nursing assistants, as provided by Code of
19.30 Federal Regulations, title 42, section 483.151 or 484.36, or alternative, comparable,
19.31 state-approved training and competency requirements.

19.32 **EFFECTIVE DATE.** This section is effective July 1, 2018.

20.1 Sec. 16. Minnesota Statutes 2016, section 256B.0659, is amended by adding a subdivision
20.2 to read:

20.3 Subd. 17a. **Rate for complex personal care assistance services.** The rate paid to a
20.4 provider for complex personal care assistance services shall be 110 percent of the rate paid
20.5 for personal care assistance services.

20.6 **EFFECTIVE DATE.** This section is effective July 1, 2018.

20.7 Sec. 17. Minnesota Statutes 2016, section 256B.0659, subdivision 21, is amended to read:

20.8 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
20.9 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
20.10 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
20.11 a format determined by the commissioner, information and documentation that includes,
20.12 but is not limited to, the following:

20.13 (1) the personal care assistance provider agency's current contact information including
20.14 address, telephone number, and e-mail address;

20.15 (2) proof of surety bond coverage. Upon new enrollment, or if the provider's Medicaid
20.16 revenue in the previous calendar year is up to and including \$300,000, the provider agency
20.17 must purchase a surety bond of \$50,000. If the Medicaid revenue in the previous year is
20.18 over \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety
20.19 bond must be in a form approved by the commissioner, must be renewed annually, and must
20.20 allow for recovery of costs and fees in pursuing a claim on the bond;

20.21 (3) proof of fidelity bond coverage in the amount of \$20,000;

20.22 (4) proof of workers' compensation insurance coverage;

20.23 (5) proof of liability insurance;

20.24 (6) a description of the personal care assistance provider agency's organization identifying
20.25 the names of all owners, managing employees, staff, board of directors, and the affiliations
20.26 of the directors, owners, or staff to other service providers;

20.27 (7) a copy of the personal care assistance provider agency's written policies and
20.28 procedures including: hiring of employees; training requirements; service delivery; and
20.29 employee and consumer safety including process for notification and resolution of consumer
20.30 grievances, identification and prevention of communicable diseases, and employee
20.31 misconduct;

21.1 (8) copies of all other forms the personal care assistance provider agency uses in the
21.2 course of daily business including, but not limited to:

21.3 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
21.4 varies from the standard time sheet for personal care assistance services approved by the
21.5 commissioner, and a letter requesting approval of the personal care assistance provider
21.6 agency's nonstandard time sheet;

21.7 (ii) the personal care assistance provider agency's template for the personal care assistance
21.8 care plan; and

21.9 (iii) the personal care assistance provider agency's template for the written agreement
21.10 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

21.11 (9) a list of all training and classes that the personal care assistance provider agency
21.12 requires of its staff providing personal care assistance services;

21.13 (10) documentation that the personal care assistance provider agency and staff have
21.14 successfully completed all the training required by this section, including the requirements
21.15 under subdivision 11, paragraph (d), if complex personal care assistance services are provided
21.16 and submitted for payment;

21.17 (11) documentation of the agency's marketing practices;

21.18 (12) disclosure of ownership, leasing, or management of all residential properties that
21.19 is used or could be used for providing home care services;

21.20 (13) documentation that the agency will use the following percentages of revenue
21.21 generated from the medical assistance rate paid for personal care assistance services for
21.22 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
21.23 care assistance choice option and 72.5 percent of revenue from other personal care assistance
21.24 providers. The revenue generated by the qualified professional and the reasonable costs
21.25 associated with the qualified professional shall not be used in making this calculation; and

21.26 (14) effective May 15, 2010, documentation that the agency does not burden recipients'
21.27 free exercise of their right to choose service providers by requiring personal care assistants
21.28 to sign an agreement not to work with any particular personal care assistance recipient or
21.29 for another personal care assistance provider agency after leaving the agency and that the
21.30 agency is not taking action on any such agreements or requirements regardless of the date
21.31 signed.

21.32 (b) Personal care assistance provider agencies shall provide the information specified
21.33 in paragraph (a) to the commissioner at the time the personal care assistance provider agency

22.1 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
22.2 the information specified in paragraph (a) from all personal care assistance providers
22.3 beginning July 1, 2009.

22.4 (c) All personal care assistance provider agencies shall require all employees in
22.5 management and supervisory positions and owners of the agency who are active in the
22.6 day-to-day management and operations of the agency to complete mandatory training as
22.7 determined by the commissioner before enrollment of the agency as a provider. Employees
22.8 in management and supervisory positions and owners who are active in the day-to-day
22.9 operations of an agency who have completed the required training as an employee with a
22.10 personal care assistance provider agency do not need to repeat the required training if they
22.11 are hired by another agency, if they have completed the training within the past three years.
22.12 By September 1, 2010, the required training must be available with meaningful access
22.13 according to title VI of the Civil Rights Act and federal regulations adopted under that law
22.14 or any guidance from the United States Health and Human Services Department. The
22.15 required training must be available online or by electronic remote connection. The required
22.16 training must provide for competency testing. Personal care assistance provider agency
22.17 billing staff shall complete training about personal care assistance program financial
22.18 management. This training is effective July 1, 2009. Any personal care assistance provider
22.19 agency enrolled before that date shall, if it has not already, complete the provider training
22.20 within 18 months of July 1, 2009. Any new owners or employees in management and
22.21 supervisory positions involved in the day-to-day operations are required to complete
22.22 mandatory training as a requisite of working for the agency. Personal care assistance provider
22.23 agencies certified for participation in Medicare as home health agencies are exempt from
22.24 the training required in this subdivision. When available, Medicare-certified home health
22.25 agency owners, supervisors, or managers must successfully complete the competency test.

22.26 Sec. 18. Minnesota Statutes 2016, section 256B.0911, subdivision 1a, is amended to read:

22.27 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

22.28 (a) Until additional requirements apply under paragraph (b), "long-term care consultation
22.29 services" means:

22.30 (1) intake for and access to assistance in identifying services needed to maintain an
22.31 individual in the most inclusive environment;

22.32 (2) providing recommendations for and referrals to cost-effective community services
22.33 that are available to the individual;

- 23.1 (3) development of an individual's person-centered community support plan;
- 23.2 (4) providing information regarding eligibility for Minnesota health care programs;
- 23.3 (5) face-to-face long-term care consultation assessments, which may be completed in a
23.4 hospital, nursing facility, intermediate care facility for persons with developmental disabilities
23.5 (ICF/DDs), regional treatment centers, or the person's current or planned residence;
- 23.6 (6) determination of home and community-based waiver and other service eligibility as
23.7 required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
23.8 determination for individuals who need an institutional level of care as determined under
23.9 subdivision 4e, based on assessment and community support plan development, appropriate
23.10 referrals to obtain necessary diagnostic information, and including an eligibility determination
23.11 for consumer-directed community supports;
- 23.12 (7) providing recommendations for institutional placement when there are no
23.13 cost-effective community services available;
- 23.14 (8) providing access to assistance to transition people back to community settings after
23.15 institutional admission; and
- 23.16 (9) providing information about competitive employment, with or without supports, for
23.17 school-age youth and working-age adults and referrals to the Disability Linkage Line and
23.18 Disability Benefits 101 to ensure that an informed choice about competitive employment
23.19 can be made. For the purposes of this subdivision, "competitive employment" means work
23.20 in the competitive labor market that is performed on a full-time or part-time basis in an
23.21 integrated setting, and for which an individual is compensated at or above the minimum
23.22 wage, but not less than the customary wage and level of benefits paid by the employer for
23.23 the same or similar work performed by individuals without disabilities.
- 23.24 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
23.25 and 3a, "long-term care consultation services" also means:
- 23.26 (1) service eligibility determination for state plan home care services identified in:
- 23.27 (i) section 256B.0625, subdivisions 7, 19a, and 19c;
- 23.28 (ii) consumer support grants under section 256.476; or
- 23.29 (iii) section 256B.85;
- 23.30 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
23.31 determination of eligibility for case management services available under sections 256B.0621,
23.32 subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

24.1 (3) determination of institutional level of care, home and community-based service
 24.2 waiver, and other service eligibility as required under section 256B.092, determination of
 24.3 eligibility for family support grants under section 252.32, semi-independent living services
 24.4 under section 252.275, and day training and habilitation services under section 256B.092;
 24.5 and

24.6 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
 24.7 and (3).

24.8 (c) "Long-term care options counseling" means the services provided by the linkage
 24.9 lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also
 24.10 includes telephone assistance and follow up once a long-term care consultation assessment
 24.11 has been completed.

24.12 (d) "Minnesota health care programs" means the medical assistance program under this
 24.13 chapter and the alternative care program under section 256B.0913.

24.14 (e) "Lead agencies" means counties administering or tribes and health plans under
 24.15 contract with the commissioner to administer long-term care consultation assessment and
 24.16 support planning services.

24.17 (f) "Person-centered planning" is a process that includes the active participation of a
 24.18 person in the planning of the person's services, including in making meaningful and informed
 24.19 choices about the person's own goals, talents, and objectives, as well as making meaningful
 24.20 and informed choices about the services the person receives. For the purposes of this section,
 24.21 "informed choice" means a voluntary choice of services by a person from all available
 24.22 service options based on accurate and complete information concerning all available service
 24.23 options and concerning the person's own preferences, abilities, goals, and objectives. In
 24.24 order for a person to make an informed choice, all available options must be developed and
 24.25 presented to the person to empower the person to make decisions.

24.26 Sec. 19. Minnesota Statutes 2016, section 256B.0911, subdivision 2b, is amended to read:

24.27 Subd. 2b. **MnCHOICES certified assessors.** (a) Each lead agency shall use certified
 24.28 assessors who have completed MnCHOICES training and the certification processes
 24.29 determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate
 24.30 best practices in assessment and support planning including person-centered planning
 24.31 ~~principals~~ principles and have a common set of skills that must ensure consistency and
 24.32 equitable access to services statewide. ~~A lead agency may choose, according to departmental~~
 24.33 ~~policies, to contract with a qualified, certified assessor to conduct assessments and~~

25.1 ~~reassessments on behalf of the lead agency.~~ Certified assessors must use person-centered
 25.2 planning principles to conduct an interview that identifies what is important to the person,
 25.3 the person's needs for supports, health and safety concerns, and the person's abilities, interests,
 25.4 and goals.

25.5 Certified assessors are responsible for:

25.6 (1) ensuring persons are offered objective, unbiased access to resources;

25.7 (2) ensuring persons have the needed information to support informed choice, including
 25.8 where and how they choose to live and the opportunity to pursue desired employment;

25.9 (3) determining level of care and eligibility for long-term services and supports;

25.10 (4) using the information gathered from the interview to develop a person-centered
 25.11 community support plan that reflects identified needs and support options within the context
 25.12 of values, interests, and goals important to the person; and

25.13 (5) providing the person with a community support plan that summarizes the person's
 25.14 assessment findings, support options, and agreed-upon next steps.

25.15 (b) MnCHOICES certified assessors are persons with a minimum of a bachelor's degree
 25.16 in social work, nursing with a public health nursing certificate, or other closely related field
 25.17 with at least one year of home and community-based experience, or a registered nurse with
 25.18 at least two years of home and community-based experience who has received training and
 25.19 certification specific to assessment and consultation for long-term care services in the state.

25.20 Sec. 20. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision
 25.21 to read:

25.22 **Subd. 3f. Long-term care reassessments and community support plan updates.**

25.23 Face-to-face reassessments must be conducted annually or as required by federal and state
 25.24 laws and rules. Reassessments build upon all previous assessments conducted and include
 25.25 a review of needs and services to identify any changes. Reassessments provide information
 25.26 to support the person's informed choice and opportunities to express choice regarding
 25.27 activities that contribute to quality of life, as well as information and opportunity to identify
 25.28 goals related to desired employment, community activities, and preferred living environment.

25.29 Reassessments allow for a review of the current support plan's effectiveness, monitoring of
 25.30 services, and the development of an updated person-centered community support plan.

25.31 Reassessments verify continued eligibility or offer alternatives as warranted and provide
 25.32 an opportunity for quality assurance of service delivery.

26.1 Sec. 21. Minnesota Statutes 2016, section 256B.0911, subdivision 4d, is amended to read:

26.2 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the
26.3 policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness
26.4 are served in the most integrated setting appropriate to their needs and have the necessary
26.5 information to make informed choices about home and community-based service options.

26.6 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing
26.7 facility must be screened prior to admission according to the requirements outlined in section
26.8 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as
26.9 required under section 256.975, subdivision 7.

26.10 (c) Individuals under 65 years of age who are admitted to nursing facilities with only a
26.11 telephone screening must receive a face-to-face assessment from the long-term care
26.12 consultation team member of the county in which the facility is located or from the recipient's
26.13 county case manager ~~within 40 calendar days of admission~~ the timeline established by the
26.14 commissioner, based on review of data.

26.15 (d) At the face-to-face assessment, the long-term care consultation team member or
26.16 county case manager must perform the activities required under subdivision 3b.

26.17 (e) For individuals under 21 years of age, a screening interview which recommends
26.18 nursing facility admission must be face-to-face and approved by the commissioner before
26.19 the individual is admitted to the nursing facility.

26.20 (f) In the event that an individual under 65 years of age is admitted to a nursing facility
26.21 on an emergency basis, the Senior LinkAge Line must be notified of the admission on the
26.22 next working day, and a face-to-face assessment as described in paragraph (c) must be
26.23 conducted ~~within 40 calendar days of admission~~ the timeline established by the commissioner,
26.24 based on review of data.

26.25 (g) At the face-to-face assessment, the long-term care consultation team member or the
26.26 case manager must present information about home and community-based options, including
26.27 consumer-directed options, so the individual can make informed choices. If the individual
26.28 chooses home and community-based services, the long-term care consultation team member
26.29 or case manager must complete a written relocation plan within 20 working days of the
26.30 visit. The plan shall describe the services needed to move out of the facility and a time line
26.31 for the move which is designed to ensure a smooth transition to the individual's home and
26.32 community.

27.1 (h) An individual under 65 years of age residing in a nursing facility shall receive a
 27.2 face-to-face assessment at least every 12 months to review the person's service choices and
 27.3 available alternatives unless the individual indicates, in writing, that annual visits are not
 27.4 desired. In this case, the individual must receive a face-to-face assessment at least once
 27.5 every 36 months for the same purposes.

27.6 (i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county
 27.7 agencies directly for face-to-face assessments for individuals under 65 years of age who
 27.8 are being considered for placement or residing in a nursing facility.

27.9 (j) Funding for preadmission screening follow-up shall be provided to the Disability
 27.10 Linkage Line for the under-60 population by the Department of Human Services to cover
 27.11 options counseling salaries and expenses to provide the services described in subdivisions
 27.12 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to
 27.13 employ, within the limits of available funding, sufficient personnel to provide preadmission
 27.14 screening follow-up services and shall seek to maximize federal funding for the service as
 27.15 provided under section 256.01, subdivision 2, paragraph (dd).

27.16 Sec. 22. Minnesota Statutes 2016, section 256B.0911, subdivision 5, is amended to read:

27.17 Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes,
 27.18 including timelines for when assessments need to be completed, required to provide the
 27.19 services in this section and shall implement integrated solutions to automate the business
 27.20 processes to the extent necessary for community support plan approval, reimbursement,
 27.21 program planning, evaluation, and policy development.

27.22 (b) The commissioner of human services shall work with lead agencies responsible for
 27.23 conducting long-term consultation services to modify the MnCHOICES application and
 27.24 assessment policies to create efficiencies while ensuring federal compliance with medical
 27.25 assistance and long-term services and supports eligibility criteria.

27.26 Sec. 23. Minnesota Statutes 2016, section 256B.0921, is amended to read:

27.27 **256B.0921 HOME AND COMMUNITY-BASED SERVICES INCENTIVE POOL.**

27.28 The commissioner of human services shall develop an initiative to provide incentives
 27.29 for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated
 27.30 competitive employment for youth under age 25 upon their graduation from school; (3)
 27.31 living in the most integrated setting; and (4) other outcomes determined by the commissioner.
 27.32 The commissioner shall seek requests for proposals and shall contract with one or more

28.1 entities to provide incentive payments for meeting identified outcomes. ~~The initial requests~~
28.2 ~~for proposals must be issued by October 1, 2016.~~

28.3 Sec. 24. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

28.4 Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision,
28.5 "implementation period" means the period beginning January 1, 2014, and ending on the
28.6 last day of the month in which the rate management system is populated with the data
28.7 necessary to calculate rates for substantially all individuals receiving home and
28.8 community-based waiver services under sections 256B.092 and 256B.49. "Banding period"
28.9 means the time period beginning on January 1, 2014, and ending upon the expiration of the
28.10 12-month period defined in paragraph (c), clause (5).

28.11 (b) For purposes of this subdivision, the historical rate for all service recipients means
28.12 the individual reimbursement rate for a recipient in effect on December 1, 2013, except
28.13 that:

28.14 (1) for a day service recipient who was not authorized to receive these waiver services
28.15 prior to January 1, 2014; added a new service or services on or after January 1, 2014; or
28.16 changed providers on or after January 1, 2014, the historical rate must be the weighted
28.17 average authorized rate for the provider number in the county of service, effective December
28.18 1, 2013; or

28.19 (2) for a unit-based service with programming or a unit-based service without
28.20 programming recipient who was not authorized to receive these waiver services prior to
28.21 January 1, 2014; added a new service or services on or after January 1, 2014; or changed
28.22 providers on or after January 1, 2014, the historical rate must be the weighted average
28.23 authorized rate for each provider number in the county of service, effective December 1,
28.24 2013; or

28.25 (3) for residential service recipients who change providers on or after January 1, 2014,
28.26 the historical rate must be set by each lead agency within their county aggregate budget
28.27 using their respective methodology for residential services effective December 1, 2013, for
28.28 determining the provider rate for a similarly situated recipient being served by that provider.

28.29 (c) The commissioner shall adjust individual reimbursement rates determined under this
28.30 section so that the unit rate is no higher or lower than:

28.31 (1) 0.5 percent from the historical rate for the implementation period;

28.32 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately
28.33 following the time period of clause (1);

29.1 (3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately
29.2 following the time period of clause (2);

29.3 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately
29.4 following the time period of clause (3);

29.5 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately
29.6 following the time period of clause (4); ~~and~~

29.7 (6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately
29.8 following the time period of clause (5). During this banding rate period, the commissioner
29.9 shall not enforce any rate decrease or increase that would otherwise result from the end of
29.10 the banding period. The commissioner shall, upon enactment, seek federal approval for the
29.11 addition of this banding period; and

29.12 (7) one percent from the rate in effect in clause (6) for the 12-month period immediately
29.13 following the time period of clause (6).

29.14 (d) The commissioner shall review all changes to rates that were in effect on December
29.15 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service
29.16 unit utilization on an annual basis as those in effect on October 31, 2013.

29.17 (e) By December 31, 2014, the commissioner shall complete the review in paragraph
29.18 (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

29.19 (f) During the banding period, the Medicaid Management Information System (MMIS)
29.20 service agreement rate must be adjusted to account for change in an individual's need. The
29.21 commissioner shall adjust the Medicaid Management Information System (MMIS) service
29.22 agreement rate by:

29.23 (1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the
29.24 individual with variables reflecting the level of service in effect on December 1, 2013;

29.25 (2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the
29.26 individual with variables reflecting the updated level of service at the time of application;
29.27 and

29.28 (3) adding to or subtracting from the Medicaid Management Information System (MMIS)
29.29 service agreement rate, the difference between the values in clauses (1) and (2).

29.30 (g) This subdivision must not apply to rates for recipients served by providers new to a
29.31 given county after January 1, 2014. Providers of personal supports services who also acted
29.32 as fiscal support entities must be treated as new providers as of January 1, 2014.

30.1 **EFFECTIVE DATE.** (a) The amendment to paragraph (b) is effective the day following
 30.2 final enactment.

30.3 (b) The amendment to paragraph (c) is effective upon federal approval. The commissioner
 30.4 of human services shall notify the revisor of statutes when federal approval is obtained.

30.5 Sec. 25. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision
 30.6 to read:

30.7 Subd. 7. **New services.** (a) A service added to section 256B.4914 after January 1, 2014,
 30.8 is not subject to rate stabilization adjustment in this section.

30.9 (b) Employment support services authorized after January 1, 2018, under the new
 30.10 employment support services definition according to the home and community-based services
 30.11 waivers for people with disabilities under sections 256B.092 and 256B.49 are not subject
 30.12 to rate stabilization adjustment in this section.

30.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

30.14 Sec. 26. Minnesota Statutes 2016, section 256B.4914, subdivision 2, is amended to read:

30.15 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
 30.16 meanings given them, unless the context clearly indicates otherwise.

30.17 (b) "Commissioner" means the commissioner of human services.

30.18 (c) "Component value" means underlying factors that are part of the cost of providing
 30.19 services that are built into the waiver rates methodology to calculate service rates.

30.20 (d) "Customized living tool" means a methodology for setting service rates that delineates
 30.21 and documents the amount of each component service included in a recipient's customized
 30.22 living service plan.

30.23 (e) "Disability waiver rates system" means a statewide system that establishes rates that
 30.24 are based on uniform processes and captures the individualized nature of waiver services
 30.25 and recipient needs.

30.26 (f) "Individual staffing" means the time spent as a one-to-one interaction specific to an
 30.27 individual recipient by staff to provide direct support and assistance with activities of daily
 30.28 living, instrumental activities of daily living, and training to participants, and is based on
 30.29 the requirements in each individual's coordinated service and support plan under section
 30.30 245D.02, subdivision 4b; any coordinated service and support plan addendum under section

31.1 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
31.2 needs must also be considered.

31.3 (g) "Lead agency" means a county, partnership of counties, or tribal agency charged
31.4 with administering waived services under sections 256B.092 and 256B.49.

31.5 (h) "Median" means the amount that divides distribution into two equal groups, one-half
31.6 above the median and one-half below the median.

31.7 (i) "Payment or rate" means reimbursement to an eligible provider for services provided
31.8 to a qualified individual based on an approved service authorization.

31.9 (j) "Rates management system" means a Web-based software application that uses a
31.10 framework and component values, as determined by the commissioner, to establish service
31.11 rates.

31.12 (k) "Recipient" means a person receiving home and community-based services funded
31.13 under any of the disability waivers.

31.14 (l) "Shared staffing" means time spent by employees, not defined under paragraph (f),
31.15 providing or available to provide more than one individual with direct support and assistance
31.16 with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph
31.17 (b); instrumental activities of daily living as defined under section 256B.0659, subdivision
31.18 1, paragraph (i); ancillary activities needed to support individual services; and training to
31.19 participants, and is based on the requirements in each individual's coordinated service and
31.20 support plan under section 245D.02, subdivision 4b; any coordinated service and support
31.21 plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider
31.22 observation of an individual's service need. Total shared staffing hours are divided
31.23 proportionally by the number of individuals who receive the shared service provisions.

31.24 (m) "Staffing ratio" means the number of recipients a service provider employee supports
31.25 during a unit of service based on a uniform assessment tool, provider observation, case
31.26 history, and the recipient's services of choice, and not based on the staffing ratios under
31.27 section 245D.31.

31.28 (n) "Unit of service" means the following:

31.29 (1) for residential support services under subdivision 6, a unit of service is a day. Any
31.30 portion of any calendar day, within allowable Medicaid rules, where an individual spends
31.31 time in a residential setting is billable as a day;

31.32 (2) for day services under subdivision 7:

32.1 (i) for day training and habilitation services, a unit of service is either:

32.2 (A) a day unit of service is defined as six or more hours of time spent providing direct
32.3 services and transportation; or

32.4 (B) a partial day unit of service is defined as fewer than six hours of time spent providing
32.5 direct services and transportation; and

32.6 (C) for new day service recipients after January 1, 2014, 15 minute units of service must
32.7 be used for fewer than six hours of time spent providing direct services and transportation;

32.8 (ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A
32.9 day unit of service is six or more hours of time spent providing direct services;

32.10 (iii) for prevocational services, a unit of service is a day or an hour. A day unit of service
32.11 is six or more hours of time spent providing direct service;

32.12 (3) for unit-based services with programming under subdivision 8:

32.13 (i) for supported living services, a unit of service is a day or 15 minutes. When a day
32.14 rate is authorized, any portion of a calendar day where an individual receives services is
32.15 billable as a day; and

32.16 (ii) for all other services, a unit of service is 15 minutes; and

32.17 (4) for unit-based services without programming under subdivision 9:

32.18 ~~(i) for respite services, a unit of service is a day or 15 minutes. When a day rate is~~
32.19 ~~authorized, any portion of a calendar day when an individual receives services is billable~~
32.20 ~~as a day; and~~

32.21 ~~(ii) for all other services, a unit of service is 15 minutes.~~

32.22 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
32.23 of human services shall notify the revisor of statutes when federal approval is obtained.

32.24 Sec. 27. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

32.25 Subd. 3. **Applicable services.** Applicable services are those authorized under the state's
32.26 home and community-based services waivers under sections 256B.092 and 256B.49,
32.27 including the following, as defined in the federally approved home and community-based
32.28 services plan:

32.29 (1) 24-hour customized living;

32.30 (2) adult day care;

- 33.1 (3) adult day care bath;
- 33.2 (4) behavioral programming;
- 33.3 (5) companion services;
- 33.4 (6) customized living;
- 33.5 (7) day training and habilitation;
- 33.6 (8) housing access coordination;
- 33.7 (9) independent living skills;
- 33.8 (10) in-home family support;
- 33.9 (11) night supervision;
- 33.10 (12) personal support;
- 33.11 (13) prevocational services;
- 33.12 (14) residential care services;
- 33.13 (15) residential support services;
- 33.14 (16) respite services;
- 33.15 (17) structured day services;
- 33.16 ~~(18) supported employment services;~~
- 33.17 ~~(19)~~ (18) supported living services;
- 33.18 ~~(20)~~ (19) transportation services; ~~and~~
- 33.19 (20) individualized home supports;
- 33.20 (21) independent living skills specialist services;
- 33.21 (22) employment exploration services;
- 33.22 (23) employment development services;
- 33.23 (24) employment support services; and
- 33.24 ~~(24)~~ (25) other services as approved by the federal government in the state home and
- 33.25 community-based services plan.

33.26 **EFFECTIVE DATE.** (a) Clause (20) is effective the day following final enactment.

33.27 (b) Clauses (21) to (24) are effective upon federal approval. The commissioner of human

33.28 services shall notify the revisor of statutes when federal approval is obtained.

34.1 Sec. 28. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

34.2 Subd. 5. **Base wage index and standard component values.** (a) The base wage index
34.3 is established to determine staffing costs associated with providing services to individuals
34.4 receiving home and community-based services. For purposes of developing and calculating
34.5 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard
34.6 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
34.7 the most recent edition of the Occupational Handbook must be used. The base wage index
34.8 must be calculated as follows:

34.9 (1) for residential direct care staff, the sum of:

34.10 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home
34.11 health aide (SOC code 39-9021); 30 percent of the median wage for nursing ~~aide~~ assistant
34.12 (SOC code ~~31-1012~~ 31-1014); and 20 percent of the median wage for social and human
34.13 services aide (SOC code 21-1093); and

34.14 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide
34.15 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
34.16 (SOC code 39-9021); 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code
34.17 ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
34.18 29-2053); and 20 percent of the median wage for social and human services aide (SOC code
34.19 21-1093);

34.20 (2) for day services, 20 percent of the median wage for nursing ~~aide~~ assistant (SOC code
34.21 ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
34.22 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
34.23 21-1093);

34.24 (3) for residential asleep-overnight staff, the wage ~~will be \$7.66 per hour~~ is the minimum
34.25 wage in Minnesota for large employers, except in a family foster care setting, the wage is
34.26 ~~\$2.80 per hour~~ 36 percent of the minimum wage in Minnesota for large employers;

34.27 (4) for behavior program analyst staff, 100 percent of the median wage for mental health
34.28 counselors (SOC code 21-1014);

34.29 (5) for behavior program professional staff, 100 percent of the median wage for clinical
34.30 counseling and school psychologist (SOC code 19-3031);

34.31 (6) for behavior program specialist staff, 100 percent of the median wage for psychiatric
34.32 technicians (SOC code 29-2053);

35.1 (7) for supportive living services staff, 20 percent of the median wage for nursing aide
 35.2 assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric
 35.3 technician (SOC code 29-2053); and 60 percent of the median wage for social and human
 35.4 services aide (SOC code 21-1093);

35.5 (8) for housing access coordination staff, ~~50~~ 100 percent of the median wage for
 35.6 community and social services specialist (SOC code 21-1099); ~~and 50 percent of the median~~
 35.7 ~~wage for social and human services aide (SOC code 21-1093);~~

35.8 (9) for in-home family support staff, 20 percent of the median wage for nursing aide
 35.9 (SOC code 31-1012); 30 percent of the median wage for community social service specialist
 35.10 (SOC code 21-1099); 40 percent of the median wage for social and human services aide
 35.11 (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC
 35.12 code 29-2053);

35.13 (10) for individualized home supports services staff, 40 percent of the median wage for
 35.14 community social service specialist (SOC code 21-1099); 50 percent of the median wage
 35.15 for social and human services aide (SOC code 21-1093); and ten percent of the median
 35.16 wage for psychiatric technician (SOC code 29-2053);

35.17 (11) for independent living skills staff, 40 percent of the median wage for community
 35.18 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
 35.19 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
 35.20 technician (SOC code 29-2053);

35.21 (12) for independent living skills specialist staff, 100 percent of mental health and
 35.22 substance abuse social worker (SOC code 21-1023);

35.23 ~~(11)~~ (13) for ~~supported~~ employment support services staff, ~~20~~ 50 percent of the median
 35.24 wage for ~~nursing aide~~ rehabilitation counselor (SOC code ~~31-1012~~ 21-1015); ~~20 percent of~~
 35.25 ~~the median wage for psychiatric technician (SOC code 29-2053); and 60~~ 50 percent of the
 35.26 median wage for community and social and human services aide specialist (SOC code
 35.27 ~~21-1093~~ 21-1099);

35.28 (14) for employment exploration services staff, 50 percent of the median wage for
 35.29 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
 35.30 community and social services specialist (SOC code 21-1099);

35.31 (15) for employment development services staff, 50 percent of the median wage for
 35.32 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
 35.33 of the median wage for community and social services specialist (SOC code 21-1099);

36.1 ~~(12)~~ (16) for adult companion staff, 50 percent of the median wage for personal and
 36.2 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
 36.3 ~~orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

36.4 ~~(13)~~ (17) for night supervision staff, 20 percent of the median wage for home health
 36.5 aide (SOC code 31-1011); 20 percent of the median wage for personal and home health
 36.6 aide (SOC code 39-9021); 20 percent of the median wage for nursing aide assistant (SOC
 36.7 code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC
 36.8 code 29-2053); and 20 percent of the median wage for social and human services aide (SOC
 36.9 code 21-1093);

36.10 ~~(14)~~ (18) for respite staff, 50 percent of the median wage for personal and home care
 36.11 aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, ~~orderlies,~~
 36.12 ~~and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

36.13 ~~(15)~~ (19) for personal support staff, 50 percent of the median wage for personal and
 36.14 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
 36.15 ~~orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

36.16 ~~(16)~~ (20) for supervisory staff, ~~the basic wage is \$17.43 per hour,~~ 100 percent of the
 36.17 median wage for community and social services specialist (SOC code 21-1099), with the
 36.18 exception of the supervisor of behavior professional, behavior analyst, and behavior
 36.19 specialists, which must be \$30.75 per hour is 100 percent of the median wage for clinical
 36.20 counseling and school psychologist (SOC code 19-3031);

36.21 ~~(17)~~ (21) for registered nurse staff, the basic wage is \$30.82 per hour, 100 percent of
 36.22 the median wage for registered nurses (SOC code 29-1141); and

36.23 ~~(18)~~ (22) for licensed practical nurse staff, the basic wage is \$18.64 per hour 100 percent
 36.24 of the median wage for licensed practical nurses (SOC code 29-2061).

36.25 (b) Component values for residential support services are:

36.26 (1) supervisory span of control ratio: 11 percent;

36.27 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

36.28 (3) employee-related cost ratio: 23.6 percent;

36.29 (4) general administrative support ratio: 13.25 percent;

36.30 (5) program-related expense ratio: 1.3 percent; and

36.31 (6) absence and utilization factor ratio: 3.9 percent.

- 37.1 (c) Component values for family foster care are:
- 37.2 (1) supervisory span of control ratio: 11 percent;
- 37.3 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 37.4 (3) employee-related cost ratio: 23.6 percent;
- 37.5 (4) general administrative support ratio: 3.3 percent;
- 37.6 (5) program-related expense ratio: 1.3 percent; and
- 37.7 (6) absence factor: 1.7 percent.
- 37.8 (d) Component values for day services for all services are:
- 37.9 (1) supervisory span of control ratio: 11 percent;
- 37.10 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 37.11 (3) employee-related cost ratio: 23.6 percent;
- 37.12 (4) program plan support ratio: 5.6 percent;
- 37.13 (5) client programming and support ratio: ten percent;
- 37.14 (6) general administrative support ratio: 13.25 percent;
- 37.15 (7) program-related expense ratio: 1.8 percent; and
- 37.16 (8) absence and utilization factor ratio: ~~3.9~~ 9.4 percent.
- 37.17 (e) Component values for unit-based services with programming are:
- 37.18 (1) supervisory span of control ratio: 11 percent;
- 37.19 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 37.20 (3) employee-related cost ratio: 23.6 percent;
- 37.21 (4) program plan supports ratio: ~~3.4~~ 15.5 percent;
- 37.22 (5) client programming and supports ratio: ~~8.6~~ 4.7 percent;
- 37.23 (6) general administrative support ratio: 13.25 percent;
- 37.24 (7) program-related expense ratio: 6.1 percent; and
- 37.25 (8) absence and utilization factor ratio: 3.9 percent.
- 37.26 (f) Component values for unit-based services without programming except respite are:
- 37.27 (1) supervisory span of control ratio: 11 percent;

38.1 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

38.2 (3) employee-related cost ratio: 23.6 percent;

38.3 (4) program plan support ratio: ~~3.1~~ 7.0 percent;

38.4 (5) client programming and support ratio: ~~8.6~~ 2.3 percent;

38.5 (6) general administrative support ratio: 13.25 percent;

38.6 (7) program-related expense ratio: ~~6.1~~ 2.9 percent; and

38.7 (8) absence and utilization factor ratio: 3.9 percent.

38.8 (g) Component values for unit-based services without programming for respite are:

38.9 (1) supervisory span of control ratio: 11 percent;

38.10 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

38.11 (3) employee-related cost ratio: 23.6 percent;

38.12 (4) general administrative support ratio: 13.25 percent;

38.13 (5) program-related expense ratio: ~~6.1~~ 2.9 percent; and

38.14 (6) absence and utilization factor ratio: 3.9 percent.

38.15 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph

38.16 (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor

38.17 Statistics available on December 31, 2016. The commissioner shall publish these updated

38.18 values and load them into the rate management system. ~~This adjustment occurs every five~~

38.19 ~~years. For adjustments in 2021 and beyond, the commissioner shall use the data available~~

38.20 ~~on December 31 of the calendar year five years prior.~~ On January 1, 2022, and every two

38.21 years thereafter, the commissioner shall update the base wage index in paragraph (a) based

38.22 on the most recently available wage data by SOC from the Bureau of Labor Statistics. The

38.23 commissioner shall publish these updated values and load them into the rate management

38.24 system.

38.25 (i) On July 1, 2017, the commissioner shall update the framework components in

38.26 ~~paragraphs (b) to (g)~~ paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f),

38.27 clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17),

38.28 for changes in the Consumer Price Index. The commissioner will adjust these values higher

38.29 or lower by the percentage change in the Consumer Price Index-All Items, United States

38.30 city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall

38.31 publish these updated values and load them into the rate management system. ~~This adjustment~~

39.1 ~~occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use~~
 39.2 ~~the data available on January 1 of the calendar year four years prior and January 1 of the~~
 39.3 ~~current calendar year. On January 1, 2022, and every two years thereafter, the commissioner~~
 39.4 ~~shall update the framework components in paragraph (d), clause (5); paragraph (e), clause~~
 39.5 ~~(5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7,~~
 39.6 ~~clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner~~
 39.7 ~~shall adjust these values higher or lower by the percentage change in the CPI-U from the~~
 39.8 ~~date of the previous update to the date of the data most recently available prior to the~~
 39.9 ~~scheduled update. The commissioner shall publish these updated values and load them into~~
 39.10 ~~the rate management system.~~

39.11 (j) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer
 39.12 Price Index items are unavailable in the future, the commissioner shall recommend to the
 39.13 legislature codes or items to update and replace missing component values.

39.14 (k) The commissioner must ensure that wage values and component values in subdivisions
 39.15 5 to 9 reflect the cost to provide the service. As determined by the commissioner, in
 39.16 consultation with stakeholders identified in section 256B.4913, subdivision 5, a provider
 39.17 enrolled to provide services with rates determined under this section must submit requested
 39.18 cost data to the commissioner to support research on the cost of providing services that have
 39.19 rates determined by the disability waiver rates system. Requested cost data may include,
 39.20 but is not limited to:

39.21 (1) worker wage costs;

39.22 (2) benefits paid;

39.23 (3) supervisor wage costs;

39.24 (4) executive wage costs;

39.25 (5) vacation, sick, and training time paid;

39.26 (6) taxes, workers' compensation, and unemployment insurance costs paid;

39.27 (7) administrative costs paid;

39.28 (8) program costs paid;

39.29 (9) transportation costs paid;

39.30 (10) vacancy rates; and

39.31 (11) other data relating to costs required to provide services requested by the
 39.32 commissioner.

40.1 (l) At least once in any five-year period, a provider must submit cost data for a fiscal
40.2 year that ended not more than 18 months prior to the submission date. The commissioner
40.3 shall provide each provider a 90-day notice prior to its submission due date. If a provider
40.4 fails to submit required reporting data, the commissioner shall provide notice to providers
40.5 that have not provided required data 30 days after the required submission date, and a second
40.6 notice for providers who have not provided required data 60 days after the required
40.7 submission date. The commissioner shall temporarily suspend payments to the provider if
40.8 cost data is not received 90 days after the required submission date. Withheld payments
40.9 shall be made once data is received by the commissioner.

40.10 (m) The commissioner shall conduct a random validation of data submitted under
40.11 paragraph (k) to ensure data accuracy. The commissioner shall analyze cost documentation
40.12 in paragraph (k) and provide recommendations for adjustments to cost components.

40.13 (n) The commissioner shall analyze cost documentation in paragraph (k) and, in
40.14 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
40.15 recommendations on component values and inflationary factor adjustments to the chairs
40.16 and ranking minority members of the legislative committees with jurisdiction over human
40.17 services every four years beginning January 1, 2020. The commissioner shall make
40.18 recommendations in conjunction with reports submitted to the legislature according to
40.19 subdivision 10, paragraph (e). The commissioner shall release business cost data in an
40.20 aggregate form, and business cost data from individual providers shall not be released except
40.21 as provided for in current law.

40.22 (o) The commissioner, in consultation with stakeholders identified in section 256B.4913,
40.23 subdivision 5, shall develop and implement a process for providing training and technical
40.24 assistance necessary to support provider submission of cost documentation required under
40.25 paragraph (k).

40.26 **EFFECTIVE DATE.** (a) The amendments to paragraphs (a) to (g) are effective January
40.27 1, 2018, except the amendment to paragraph (d), clause (8), which is effective January 1,
40.28 2019, and the amendment to paragraph (a), clause (10), which is effective the day following
40.29 final enactment.

40.30 (b) The amendments to paragraphs (h) to (o) are effective the day following final
40.31 enactment.

41.1 Sec. 29. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

41.2 Subd. 6. **Payments for residential support services.** (a) Payments for residential support
41.3 services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22,
41.4 must be calculated as follows:

41.5 (1) determine the number of shared staffing and individual direct staff hours to meet a
41.6 recipient's needs provided on site or through monitoring technology;

41.7 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
41.8 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
41.9 5. This is defined as the direct-care rate;

41.10 (3) for a recipient requiring customization for deaf and hard-of-hearing language
41.11 accessibility under subdivision 12, add the customization rate provided in subdivision 12
41.12 to the result of clause (2). This is defined as the customized direct-care rate;

41.13 (4) multiply the number of shared and individual direct staff hours provided on site or
41.14 through monitoring technology and nursing hours by the appropriate staff wages in
41.15 subdivision 5, paragraph (a), or the customized direct-care rate;

41.16 (5) multiply the number of shared and individual direct staff hours provided on site or
41.17 through monitoring technology and nursing hours by the product of the supervision span
41.18 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
41.19 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

41.20 (6) combine the results of clauses (4) and (5), excluding any shared and individual direct
41.21 staff hours provided through monitoring technology, and multiply the result by one plus
41.22 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
41.23 clause (2). This is defined as the direct staffing cost;

41.24 (7) for employee-related expenses, multiply the direct staffing cost, excluding any shared
41.25 and individual direct staff hours provided through monitoring technology, by one plus the
41.26 employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

41.27 (8) for client programming and supports, the commissioner shall add \$2,179; and

41.28 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
41.29 customized for adapted transport, based on the resident with the highest assessed need.

41.30 (b) The total rate must be calculated using the following steps:

42.1 (1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared
42.2 and individual direct staff hours provided through monitoring technology that was excluded
42.3 in clause (7);

42.4 (2) sum the standard general and administrative rate, the program-related expense ratio,
42.5 and the absence and utilization ratio;

42.6 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
42.7 payment amount; and

42.8 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
42.9 adjust for regional differences in the cost of providing services.

42.10 (c) The payment methodology for customized living, 24-hour customized living, and
42.11 residential care services must be the customized living tool. Revisions to the customized
42.12 living tool must be made to reflect the services and activities unique to disability-related
42.13 recipient needs.

42.14 (d) For individuals enrolled prior to January 1, 2014, the days of service authorized must
42.15 meet or exceed the days of service used to convert service agreements in effect on December
42.16 1, 2013, and must not result in a reduction in spending or service utilization due to conversion
42.17 during the implementation period under section 256B.4913, subdivision 4a. If during the
42.18 implementation period, an individual's historical rate, including adjustments required under
42.19 section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate
42.20 determined in this subdivision, the number of days authorized for the individual is 365.

42.21 (e) The number of days authorized for all individuals enrolling after January 1, 2014,
42.22 in residential services must include every day that services start and end.

42.23 Sec. 30. Minnesota Statutes 2016, section 256B.4914, subdivision 7, is amended to read:

42.24 Subd. 7. **Payments for day programs.** Payments for services with day programs
42.25 including adult day care, day treatment and habilitation, prevocational services, and structured
42.26 day services must be calculated as follows:

42.27 (1) determine the number of units of service and staffing ratio to meet a recipient's needs:

42.28 (i) the staffing ratios for the units of service provided to a recipient in a typical week
42.29 must be averaged to determine an individual's staffing ratio; and

42.30 (ii) the commissioner, in consultation with service providers, shall develop a uniform
42.31 staffing ratio worksheet to be used to determine staffing ratios under this subdivision;

- 43.1 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
43.2 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
43.3 5;
- 43.4 (3) for a recipient requiring customization for deaf and hard-of-hearing language
43.5 accessibility under subdivision 12, add the customization rate provided in subdivision 12
43.6 to the result of clause (2). This is defined as the customized direct-care rate;
- 43.7 (4) multiply the number of day program direct staff hours and nursing hours by the
43.8 appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;
- 43.9 (5) multiply the number of day direct staff hours by the product of the supervision span
43.10 of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision
43.11 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);
- 43.12 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
43.13 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause
43.14 (2). This is defined as the direct staffing rate;
- 43.15 (7) for program plan support, multiply the result of clause (6) by one plus the program
43.16 plan support ratio in subdivision 5, paragraph (d), clause (4);
- 43.17 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
43.18 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);
- 43.19 (9) for client programming and supports, multiply the result of clause (8) by one plus
43.20 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);
- 43.21 (10) for program facility costs, add \$19.30 per week with consideration of staffing ratios
43.22 to meet individual needs;
- 43.23 (11) for adult day bath services, add \$7.01 per 15 minute unit;
- 43.24 (12) this is the subtotal rate;
- 43.25 (13) sum the standard general and administrative rate, the program-related expense ratio,
43.26 and the absence and utilization factor ratio;
- 43.27 (14) divide the result of clause (12) by one minus the result of clause (13). This is the
43.28 total payment amount;
- 43.29 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
43.30 to adjust for regional differences in the cost of providing services;

44.1 (16) for transportation provided as part of day training and habilitation for an individual
44.2 who does not require a lift, add:

44.3 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without
44.4 a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared ride in a
44.5 vehicle with a lift;

44.6 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without
44.7 a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared ride in a
44.8 vehicle with a lift;

44.9 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without
44.10 a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared ride in a
44.11 vehicle with a lift; or

44.12 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
44.13 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
44.14 with a lift;

44.15 (17) for transportation provided as part of day training and habilitation for an individual
44.16 who does require a lift, add:

44.17 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a
44.18 lift, and \$15.05 for a shared ride in a vehicle with a lift;

44.19 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
44.20 lift, and \$28.16 for a shared ride in a vehicle with a lift;

44.21 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a
44.22 lift, and \$58.76 for a shared ride in a vehicle with a lift; or

44.23 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift,
44.24 and \$80.93 for a shared ride in a vehicle with a lift.

44.25 Sec. 31. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

44.26 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
44.27 services with programming, including behavior programming, housing access coordination,
44.28 in-home family support, independent living skills training, independent living skills specialist
44.29 services, individualized home supports, hourly supported living services, employment
44.30 exploration services, employment development services, and supported employment support
44.31 services provided to an individual outside of any day or residential service plan must be

- 45.1 calculated as follows, unless the services are authorized separately under subdivision 6 or
45.2 7:
- 45.3 (1) determine the number of units of service to meet a recipient's needs;
- 45.4 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
45.5 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
45.6 5;
- 45.7 (3) for a recipient requiring customization for deaf and hard-of-hearing language
45.8 accessibility under subdivision 12, add the customization rate provided in subdivision 12
45.9 to the result of clause (2). This is defined as the customized direct-care rate;
- 45.10 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
45.11 5, paragraph (a), or the customized direct-care rate;
- 45.12 (5) multiply the number of direct staff hours by the product of the supervision span of
45.13 control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
45.14 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);
- 45.15 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
45.16 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause
45.17 (2). This is defined as the direct staffing rate;
- 45.18 (7) for program plan support, multiply the result of clause (6) by one plus the program
45.19 plan supports ratio in subdivision 5, paragraph (e), clause (4);
- 45.20 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
45.21 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);
- 45.22 (9) for client programming and supports, multiply the result of clause (8) by one plus
45.23 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);
- 45.24 (10) this is the subtotal rate;
- 45.25 (11) sum the standard general and administrative rate, the program-related expense ratio,
45.26 and the absence and utilization factor ratio;
- 45.27 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
45.28 total payment amount;
- 45.29 (13) for ~~supported~~ employment support services provided in a shared manner, divide
45.30 the total payment amount in clause (12) by the number of service recipients, not to exceed
45.31 ~~three~~ six. For independent living skills training and individualized home supports provided

46.1 in a shared manner, divide the total payment amount in clause (12) by the number of service
46.2 recipients, not to exceed two; and

46.3 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
46.4 to adjust for regional differences in the cost of providing services.

46.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

46.6 Sec. 32. Minnesota Statutes 2016, section 256B.4914, subdivision 9, is amended to read:

46.7 Subd. 9. **Payments for unit-based services without programming.** Payments for
46.8 unit-based services without programming, including night supervision, personal support,
46.9 respite, and companion care provided to an individual outside of any day or residential
46.10 service plan must be calculated as follows unless the services are authorized separately
46.11 under subdivision 6 or 7:

46.12 (1) for all services except respite, determine the number of units of service to meet a
46.13 recipient's needs;

46.14 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
46.15 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

46.16 (3) for a recipient requiring customization for deaf and hard-of-hearing language
46.17 accessibility under subdivision 12, add the customization rate provided in subdivision 12
46.18 to the result of clause (2). This is defined as the customized direct care rate;

46.19 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
46.20 5 or the customized direct care rate;

46.21 (5) multiply the number of direct staff hours by the product of the supervision span of
46.22 control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
46.23 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

46.24 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
46.25 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause
46.26 (2). This is defined as the direct staffing rate;

46.27 (7) for program plan support, multiply the result of clause (6) by one plus the program
46.28 plan support ratio in subdivision 5, paragraph (f), clause (4);

46.29 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
46.30 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

47.1 (9) for client programming and supports, multiply the result of clause (8) by one plus
47.2 the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

47.3 (10) this is the subtotal rate;

47.4 (11) sum the standard general and administrative rate, the program-related expense ratio,
47.5 and the absence and utilization factor ratio;

47.6 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
47.7 total payment amount;

47.8 (13) for respite services, determine the number of day units of service to meet an
47.9 individual's needs;

47.10 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
47.11 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

47.12 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision
47.13 12, add the customization rate provided in subdivision 12 to the result of clause (14). This
47.14 is defined as the customized direct care rate;

47.15 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision
47.16 5, paragraph (a);

47.17 (17) multiply the number of direct staff hours by the product of the supervisory span of
47.18 control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
47.19 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (20);

47.20 (18) combine the results of clauses (16) and (17), and multiply the result by one plus
47.21 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g),
47.22 clause (2). This is defined as the direct staffing rate;

47.23 (19) for employee-related expenses, multiply the result of clause (18) by one plus the
47.24 employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

47.25 (20) this is the subtotal rate;

47.26 (21) sum the standard general and administrative rate, the program-related expense ratio,
47.27 and the absence and utilization factor ratio;

47.28 (22) divide the result of clause (20) by one minus the result of clause (21). This is the
47.29 total payment amount; and

47.30 (23) adjust the result of clauses (12) and (22) by a factor to be determined by the
47.31 commissioner to adjust for regional differences in the cost of providing services.

48.1 Sec. 33. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

48.2 Subd. 10. **Updating payment values and additional information.** (a) From January
48.3 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform
48.4 procedures to refine terms and adjust values used to calculate payment rates in this section.

48.5 (b) No later than July 1, 2014, the commissioner shall, within available resources, begin
48.6 to conduct research and gather data and information from existing state systems or other
48.7 outside sources on the following items:

48.8 (1) differences in the underlying cost to provide services and care across the state; and

48.9 (2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and
48.10 units of transportation for all day services, which must be collected from providers using
48.11 the rate management worksheet and entered into the rates management system; and

48.12 (3) the distinct underlying costs for services provided by a license holder under sections
48.13 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided
48.14 by a license holder certified under section 245D.33.

48.15 (c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid
48.16 set of rates management system data, the commissioner, in consultation with stakeholders,
48.17 shall analyze for each service the average difference in the rate on December 31, 2013, and
48.18 the framework rate at the individual, provider, lead agency, and state levels. The
48.19 commissioner shall issue semiannual reports to the stakeholders on the difference in rates
48.20 by service and by county during the banding period under section 256B.4913, subdivision
48.21 4a. The commissioner shall issue the first report by October 1, 2014, and the final report
48.22 shall be issued by December 31, 2018.

48.23 (d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall
48.24 begin the review and evaluation of the following values already in subdivisions 6 to 9, or
48.25 issues that impact all services, including, but not limited to:

48.26 (1) values for transportation rates ~~for day services;~~

48.27 ~~(2) values for transportation rates in residential services;~~

48.28 ~~(3)~~ (2) values for services where monitoring technology replaces staff time;

48.29 ~~(4)~~ (3) values for indirect services;

48.30 ~~(5)~~ (4) values for nursing;

48.31 ~~(6) component values for independent living skills;~~

- 49.1 ~~(7) component values for family foster care that reflect licensing requirements;~~
- 49.2 ~~(8) adjustments to other components to replace the budget neutrality factor;~~
- 49.3 ~~(9) remote monitoring technology for nonresidential services;~~
- 49.4 ~~(10) values for basic and intensive services in residential services;~~
- 49.5 ~~(11)~~ (5) values for the facility use rate in day services, and the weightings used in the
- 49.6 day service ratios and adjustments to those weightings;
- 49.7 ~~(12)~~ (6) values for workers' compensation as part of employee-related expenses;
- 49.8 ~~(13)~~ (7) values for unemployment insurance as part of employee-related expenses;
- 49.9 ~~(14) a component value to reflect costs for individuals with rates previously adjusted~~
- 49.10 ~~for the inclusion of group residential housing rate 3 costs, only for any individual enrolled~~
- 49.11 ~~as of December 31, 2013; and~~
- 49.12 ~~(15)~~ (8) any changes in state or federal law with ~~an~~ a direct impact on the underlying
- 49.13 cost of providing home and community-based services; and
- 49.14 (9) outcome measures, determined by the commissioner, for home and community-based
- 49.15 services rates determined under this section.
- 49.16 (e) The commissioner shall report to the chairs and the ranking minority members of
- 49.17 the legislative committees and divisions with jurisdiction over health and human services
- 49.18 policy and finance with the information and data gathered under paragraphs (b) to (d) on
- 49.19 the following dates:
- 49.20 (1) January 15, 2015, with preliminary results and data;
- 49.21 (2) January 15, 2016, with a status implementation update, and additional data and
- 49.22 summary information;
- 49.23 (3) January 15, 2017, with the full report; and
- 49.24 (4) January 15, ~~2019~~ 2020, with another full report, and a full report once every four
- 49.25 years thereafter.
- 49.26 ~~(f) Based on the commissioner's evaluation of the information and data collected in~~
- 49.27 ~~paragraphs (b) to (d), the commissioner shall make recommendations to the legislature by~~
- 49.28 ~~January 15, 2015, to address any issues identified during the first year of implementation.~~
- 49.29 ~~After January 15, 2015, the commissioner may make recommendations to the legislature~~
- 49.30 ~~to address potential issues.~~

50.1 ~~(g)~~ (f) The commissioner shall implement a regional adjustment factor to all rate
 50.2 calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July
 50.3 1, 2017, the commissioner shall renew analysis and implement changes to the regional
 50.4 adjustment factors when adjustments required under subdivision 5, paragraph (h), occur.
 50.5 Prior to implementation, the commissioner shall consult with stakeholders on the
 50.6 methodology to calculate the adjustment.

50.7 ~~(h)~~ (g) The commissioner shall provide a public notice via LISTSERV in October of
 50.8 each year beginning October 1, 2014, containing information detailing legislatively approved
 50.9 changes in:

50.10 (1) calculation values including derived wage rates and related employee and
 50.11 administrative factors;

50.12 (2) service utilization;

50.13 (3) county and tribal allocation changes; and

50.14 (4) information on adjustments made to calculation values and the timing of those
 50.15 adjustments.

50.16 The information in this notice must be effective January 1 of the following year.

50.17 ~~(i) No later than July 1, 2016, the commissioner shall develop and implement, in~~
 50.18 ~~consultation with stakeholders, a methodology sufficient to determine the shared staffing~~
 50.19 ~~levels necessary to meet, at a minimum, health and welfare needs of individuals who will~~
 50.20 ~~be living together in shared residential settings, and the required shared staffing activities~~
 50.21 ~~described in subdivision 2, paragraph (1). This determination methodology must ensure~~
 50.22 ~~staffing levels are adaptable to meet the needs and desired outcomes for current and~~
 50.23 ~~prospective residents in shared residential settings.~~

50.24 ~~(j)~~ (h) When the available shared staffing hours in a residential setting are insufficient
 50.25 to meet the needs of an individual who enrolled in residential services after January 1, 2014,
 50.26 or insufficient to meet the needs of an individual with a service agreement adjustment
 50.27 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours
 50.28 shall be used.

50.29 (i) The commissioner shall study the underlying cost of absence and utilization for day
 50.30 services. Based on the commissioner's evaluation of the data collected under this paragraph,
 50.31 the commissioner shall make recommendations to the legislature by January 15, 2018, for
 50.32 changes, if any, to the absence and utilization factor ratio component value for day services.

51.1 (j) Beginning July 1, 2017, the commissioner shall collect transportation and trip
51.2 information for all day services through the rates management system.

51.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

51.4 Sec. 34. Minnesota Statutes 2016, section 256B.4914, subdivision 16, is amended to read:

51.5 Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following
51.6 adjustments to the rate generated by the framework to assure budget neutrality until the rate
51.7 information is available to implement paragraph (b). The rate generated by the framework
51.8 shall be multiplied by the appropriate factor, as designated below:

51.9 (1) for residential services: 1.003;

51.10 (2) for day services: 1.000;

51.11 (3) for unit-based services with programming: 0.941; and

51.12 (4) for unit-based services without programming: 0.796.

51.13 (b) Within 12 months of January 1, 2014, the commissioner shall compare estimated
51.14 spending for all home and community-based waiver services under the new payment rates
51.15 defined in subdivisions 6 to 9 with estimated spending for the same recipients and services
51.16 under the rates in effect on July 1, 2013. This comparison must distinguish spending under
51.17 each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and
51.18 services for one or more service months after the new rates have gone into effect. The
51.19 commissioner shall consult with the commissioner of management and budget on this
51.20 analysis to ensure budget neutrality. If estimated spending under the new rates for services
51.21 under one or more subdivisions differs in this comparison by 0.3 percent or more, the
51.22 commissioner shall assure aggregate budget neutrality across all service areas by adjusting
51.23 the budget neutrality factor in paragraph (a) in each subdivision so that total estimated
51.24 spending for each subdivision under the new rates matches estimated spending under the
51.25 rates in effect on July 1, 2013.

51.26 (c) A service rate developed using values in subdivision 5, paragraph (a), clause (10),
51.27 is not subject to budget neutrality adjustments.

51.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

52.1 Sec. 35. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision
52.2 to read:

52.3 Subd. 1a. **Culturally affirmative.** "Culturally affirmative" describes services that are
52.4 designed and delivered within the context of the culture, language, and life experiences of
52.5 a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing.

52.6 Sec. 36. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

52.7 Subd. 2. **Deaf.** "Deaf" means a hearing loss of such severity that the individual must
52.8 depend primarily on visual communication such as American Sign Language or other signed
52.9 language, visual and manual means of communication such as signing systems in English
52.10 or Cued Speech, writing, lip speech reading, ~~manual communication~~, and gestures.

52.11 Sec. 37. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision
52.12 to read:

52.13 Subd. 2c. **Interpreting services.** "Interpreting services" means services that include:

52.14 (1) interpreting between a spoken language, such as English, and a visual language, such
52.15 as American Sign Language;

52.16 (2) interpreting between a spoken language and a visual representation of a spoken
52.17 language, such as Cued Speech and signing systems in English;

52.18 (3) interpreting within one language where the interpreter uses natural gestures and
52.19 silently repeats the spoken message, replacing some words or phrases to give higher visibility
52.20 on the lips;

52.21 (4) interpreting using low vision or tactile methods for persons who have a combined
52.22 hearing and vision loss or are deafblind; and

52.23 (5) interpreting from one communication mode or language into another communication
52.24 mode or language that is linguistically and culturally appropriate for the participants in the
52.25 communication exchange.

52.26 Sec. 38. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision
52.27 to read:

52.28 Subd. 6. **Real-time captioning.** "Real-time captioning" means a method of captioning
52.29 in which a caption is simultaneously prepared and displayed or transmitted at the time of
52.30 origination by specially trained real-time captioners.

53.1 Sec. 39. Minnesota Statutes 2016, section 256C.233, subdivision 1, is amended to read:

53.2 Subdivision 1. **Deaf and Hard-of-Hearing Services Division.** The commissioners of
 53.3 ~~human services, education, employment and economic development, and health shall create~~
 53.4 ~~a distinct and separate organizational unit to be known as~~ advise the commissioner of human
 53.5 services on the activities of the Deaf and Hard-of-Hearing Services Division to address.
 53.6 This division addresses the developmental, social, educational, and occupational and
 53.7 social-emotional needs of persons who are deaf, persons who are deafblind, and persons
 53.8 who are hard-of-hearing persons through a statewide network of collaborative services and
 53.9 by coordinating the promulgation of public policies, regulations, legislation, and programs
 53.10 affecting advocates on behalf of and provides information and training about how to best
 53.11 serve persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing
 53.12 persons. An interdepartmental management team shall advise the activities of the Deaf and
 53.13 ~~Hard-of-Hearing Services Division.~~ The commissioner of human services shall coordinate
 53.14 the work of the interagency ~~management team~~ advisers and receive legislative appropriations
 53.15 for the division.

53.16 Sec. 40. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

53.17 Subd. 2. **Responsibilities.** The Deaf and Hard-of-Hearing Services Division shall:

53.18 (1) establish and maintain a statewide network of regional ~~service centers~~ culturally
 53.19 affirmative services for Minnesotans who are deaf, Minnesotans who are deafblind, and
 53.20 Minnesotans who are hard-of-hearing Minnesotans;

53.21 (2) ~~assist work across divisions within the Departments~~ Department of Human Services,
 53.22 ~~Education, and Employment and Economic Development to coordinate the promulgation~~
 53.23 ~~and implementation of public policies, regulations, legislation, programs, and services~~
 53.24 ~~affecting~~ as well as with other agencies and counties, to ensure that there is an understanding
 53.25 of:

53.26 (i) the communication challenges faced by persons who are deaf, persons who are
 53.27 deafblind, and persons who are hard-of-hearing persons;

53.28 (ii) the best practices for accommodating and mitigating communication challenges;
 53.29 and

53.30 (iii) the legal requirements for providing access to and effective communication with
 53.31 persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing; and

53.32 (3) ~~provide a coordinated system of~~ assess the supply and demand statewide interpreting
 53.33 ~~or for interpreter referral services; and real-time captioning services, implement strategies~~

- 54.1 to provide greater access to these services in areas without sufficient supply, and build the
54.2 base of service providers across the state;
- 54.3 (4) maintain a statewide information resource that includes contact information and
54.4 professional certification credentials of interpreting service providers and real-time captioning
54.5 service providers;
- 54.6 (5) provide culturally affirmative mental health services to persons who are deaf, persons
54.7 who are deafblind, and persons who are hard-of-hearing who:
- 54.8 (i) use a visual language such as American Sign Language or a tactile form of a language;
54.9 or
- 54.10 (ii) otherwise need culturally affirmative therapeutic services;
- 54.11 (6) research and develop best practices and recommendations for emerging issues;
- 54.12 (7) provide as much information as practicable on the division's stand-alone Web site
54.13 in American Sign Language; and
- 54.14 (8) report to the chairs and ranking minority members of the legislative committees with
54.15 jurisdiction over human services biennially, beginning on January 1, 2019, on the following:
- 54.16 (i) the number of regional service center staff, the location of the office of each staff
54.17 person, other service providers with which they are colocated, the number of people served
54.18 by each staff person and a breakdown of whether each person was served on-site or off-site,
54.19 and for those served off-site, a list of locations where services were delivered and the number
54.20 who were served in-person and the number who were served via technology;
- 54.21 (ii) the amount and percentage of the division budget spent on reasonable
54.22 accommodations for staff;
- 54.23 (iii) the number of people who use demonstration equipment and consumer evaluations
54.24 of the experience;
- 54.25 (iv) the number of training sessions provided by division staff, the topics covered, the
54.26 number of participants, and consumer evaluations, including a breakdown by delivery
54.27 method such as in-person or via technology;
- 54.28 (v) the number of training sessions hosted at a division location provided by another
54.29 service provider, the topics covered, the number of participants, and consumer evaluations,
54.30 including a breakdown by delivery method such as in-person or via technology;
- 54.31 (vi) for each grant awarded, the amount awarded to the grantee and a summary of the
54.32 grantee's results, including consumer evaluations of the services or products provided;

55.1 (vii) the number of people on waiting lists for any services provided by division staff
 55.2 or for services or equipment funded through grants awarded by the division;

55.3 (viii) the amount of time staff spent driving to appointments to deliver direct one-to-one
 55.4 client services in locations outside of the regional service centers;

55.5 (ix) the amount spent on mileage reimbursement and the number of clients who received
 55.6 mileage reimbursement for traveling to the regional service centers for services; and

55.7 (x) the regional needs and feedback on addressing service gaps identified by the advisory
 55.8 committees.

55.9 Sec. 41. Minnesota Statutes 2016, section 256C.24, subdivision 1, is amended to read:

55.10 Subdivision 1. **Location.** The Deaf and Hard-of-Hearing Services Division shall establish
 55.11 ~~up to eight~~ at least six regional service centers for persons who are deaf and persons who
 55.12 are hard-of-hearing persons. The centers shall be distributed regionally to provide access
 55.13 for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing
 55.14 persons in all parts of the state.

55.15 Sec. 42. Minnesota Statutes 2016, section 256C.24, subdivision 2, is amended to read:

55.16 Subd. 2. **Responsibilities.** Each regional service center shall:

55.17 ~~(1) serve as a central entry point for~~ establish connections and collaborations and explore
 55.18 co-locating with other public and private entities providing services to persons who are
 55.19 deaf, persons who are deafblind, and persons who are hard-of-hearing persons in need of
 55.20 services and make referrals to the services needed in the region;

55.21 (2) for those in need of services, assist in coordinating services between service providers
 55.22 and persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing,
 55.23 and the persons' families, and make referrals to the services needed;

55.24 ~~(2)(3)~~ employ staff trained to work with persons who are deaf, persons who are deafblind,
 55.25 and persons who are hard-of-hearing persons;

55.26 ~~(3)~~ (4) if adequate services are not available from another public or private service
 55.27 provider in the region, provide to all individual assistance to persons who are deaf, persons
 55.28 who are deafblind, and persons who are hard-of-hearing persons access to interpreter services
 55.29 which are necessary to help them obtain services, and the persons' families. Individual
 55.30 culturally affirmative assistance may be provided using technology only in areas of the state
 55.31 where a person has access to sufficient quality telecommunications or broadband services

56.1 to allow effective communication. When a person who is deaf, a person who is deafblind,
 56.2 or a person who is hard-of-hearing does not have access to sufficient telecommunications
 56.3 or broadband service, individual assistance shall be available in person;

56.4 (5) identify regional training needs, work with deaf and hard-of-hearing services training
 56.5 staff, and collaborate with others to deliver training for persons who are deaf, persons who
 56.6 are deafblind, and persons who are hard-of-hearing, and the persons' families, and other
 56.7 service providers about subjects including the persons' rights under the law, American Sign
 56.8 Language, and the impact of hearing loss and options for accommodating it;

56.9 ~~(4) implement a plan to provide loaned equipment and resource materials to deaf,~~
 56.10 ~~deafblind, and hard-of-hearing~~ (6) have a mobile or permanent lab where persons who are
 56.11 deaf, persons who are deafblind, and persons who are hard-of-hearing can try a selection
 56.12 of modern assistive technology and equipment to determine what would best meet the
 56.13 persons' needs;

56.14 ~~(5) cooperate with responsible departments and administrative authorities to provide~~
 56.15 ~~access for deaf, deafblind, and hard-of-hearing persons to services provided by state, county,~~
 56.16 ~~and regional agencies;~~

56.17 ~~(6)~~ (7) collaborate with the Resource Center for the Deaf and Hard-of-Hearing Persons,
 56.18 other divisions of the Department of Education, and local school districts to develop and
 56.19 deliver programs and services for families with children who are deaf, children who are
 56.20 deafblind, or children who are hard-of-hearing children and to support school personnel
 56.21 serving these children;

56.22 ~~(7) when possible,~~ (8) provide training to the social service or income maintenance staff
 56.23 employed by counties or by organizations with whom counties contract for services to
 56.24 ensure that communication barriers which prevent persons who are deaf, persons who are
 56.25 deafblind, and persons who are hard-of-hearing persons from using services are removed;

56.26 ~~(8) when possible,~~ (9) provide training to ~~state and regional~~ human service agencies in
 56.27 the region regarding program access for persons who are deaf, persons who are deafblind,
 56.28 and persons who are hard-of-hearing persons; and

56.29 ~~(9)~~ (10) assess the ongoing need and supply of services for persons who are deaf, persons
 56.30 who are deafblind, and persons who are hard-of-hearing persons in all parts of the state,
 56.31 annually consult with the division's advisory committees to identify regional needs and
 56.32 solicit feedback on addressing service gaps, and cooperate with public and private service
 56.33 providers to develop these services;

57.1 (11) provide culturally affirmative mental health services to persons who are deaf,
 57.2 persons who are deafblind, and persons who are hard-of-hearing who:

57.3 (i) use a visual language such as American Sign Language or a tactile form of a language;

57.4 or

57.5 (ii) otherwise need culturally affirmative therapeutic services; and

57.6 (12) establish partnerships with state and regional entities statewide that have the
 57.7 technological capacity to provide Minnesotans with virtual access to the division's services
 57.8 and division-sponsored training via technology.

57.9 Sec. 43. Minnesota Statutes 2016, section 256C.261, is amended to read:

57.10 **256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND PERSONS.**

57.11 (a) The commissioner of human services shall ~~combine the existing biennial base level~~
 57.12 ~~funding for deafblind services into a single grant program. At least 35 percent of the total~~
 57.13 ~~funding is awarded for services and other supports to deafblind children and their families~~
 57.14 ~~and at least 25 percent is awarded for services and other supports to deafblind adults. use~~
 57.15 at least 35 percent of the deafblind services biennial base level grant funding for services
 57.16 and other supports for a child who is deafblind and the child's family. The commissioner
 57.17 shall use at least 25 percent of the deafblind services biennial base level grant funding for
 57.18 services and other supports for an adult who is deafblind.

57.19 The commissioner shall award grants for the purposes of:

57.20 (1) providing services and supports to ~~individuals~~ persons who are deafblind; and

57.21 (2) developing and providing training to counties and the network of senior citizen
 57.22 service providers. The purpose of the training grants is to teach counties how to use existing
 57.23 programs that capture federal financial participation to meet the needs of eligible persons
 57.24 who are deafblind persons and to build capacity of senior service programs to meet the
 57.25 needs of seniors with a dual sensory hearing and vision loss.

57.26 (b) The commissioner may make grants:

57.27 (1) for services and training provided by organizations; and

57.28 (2) to develop and administer consumer-directed services.

57.29 (c) Consumer-directed services shall be provided in whole by grant-funded providers.

57.30 The deaf and hard-of-hearing regional service centers shall not provide any aspect of a
 57.31 grant-funded consumer-directed services program.

58.1 ~~(e)~~ (d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant
 58.2 under paragraph (a).

58.3 ~~(d)~~ (e) Deafblind service providers may, but are not required to, provide intervenor
 58.4 services as part of the service package provided with grant funds under this section.

58.5 Sec. 44. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS**
 58.6 **BUDGET METHODOLOGY EXCEPTION.**

58.7 (a) No later than September 30, 2017, if necessary, the commissioner of human services
 58.8 shall submit an amendment to the Centers for Medicare and Medicaid Services for the home
 58.9 and community-based services waivers authorized under Minnesota Statutes, sections
 58.10 256B.092 and 256B.49, to expand the exception to the consumer-directed community
 58.11 supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide
 58.12 up to 30 percent more funds for either:

58.13 (1) consumer-directed community supports participants who have a coordinated service
 58.14 and support plan which identifies the need for an increased amount of services or supports
 58.15 under consumer-directed community supports than the amount they are currently receiving
 58.16 under the consumer-directed community supports budget methodology:

58.17 (i) to increase the amount of time a person works or otherwise improves employment
 58.18 opportunities;

58.19 (ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes,
 58.20 section 256D.44, subdivision 5, paragraph (f), clause (1), item (ii), or paragraph (g); or

58.21 (iii) to develop and implement a positive behavior support plan; or

58.22 (2) home and community-based waiver participants who are currently using licensed
 58.23 providers for (i) employment supports or services during the day; or (ii) residential services,
 58.24 either of which cost more annually than the person would spend under a consumer-directed
 58.25 community supports plan for any or all of the supports needed to meet the goals identified
 58.26 in paragraph (a), clause (1), items (i), (ii), and (iii).

58.27 (b) The exception under paragraph (a), clause (1), is limited to those persons who can
 58.28 demonstrate that they will have to discontinue using consumer-directed community supports
 58.29 and accept other non-self-directed waiver services because their supports needed for the
 58.30 goals described in paragraph (a), clause (1), items (i), (ii), and (iii), cannot be met within
 58.31 the consumer-directed community supports budget limits.

59.1 (c) The exception under paragraph (a), clause (2), is limited to those persons who can
 59.2 demonstrate that, upon choosing to become a consumer-directed community supports
 59.3 participant, the total cost of services, including the exception, will be less than the cost of
 59.4 current waiver services.

59.5 **EFFECTIVE DATE.** The exception under this section is effective October 1, 2017, or
 59.6 upon federal approval, whichever is later. Notwithstanding any other law to the contrary,
 59.7 the exception in Laws 2016, chapter 144, section 1, remains in effect until the exception
 59.8 under Laws 2015, chapter 71, article 7, section 54, or under this section becomes effective,
 59.9 whichever occurs first. The commissioner of human services shall notify the revisor of
 59.10 statutes when federal approval is obtained.

59.11 Sec. 45. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
 59.12 **METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND**
 59.13 **CRISIS RESIDENTIAL SETTINGS.**

59.14 (a) By September 30, 2017, the commissioner shall establish an institutional and crisis
 59.15 bed consumer-directed community supports budget exception process in the home and
 59.16 community-based services waivers under Minnesota Statutes, sections 256B.092 and
 59.17 256B.49. This budget exception process shall be available for any individual who:

59.18 (1) is not offered available and appropriate services within 60 days since approval for
 59.19 discharge from the individual's current institutional setting; and

59.20 (2) requires services that are more expensive than appropriate services provided in a
 59.21 noninstitutional setting using the consumer-directed community supports option.

59.22 (b) Institutional settings for purposes of this exception include intermediate care facilities
 59.23 for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka
 59.24 Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget
 59.25 exception shall be limited to no more than the amount of appropriate services provided in
 59.26 a noninstitutional setting as determined by the lead agency managing the individual's home
 59.27 and community-based services waiver. The lead agency shall notify the Department of
 59.28 Human Services of the budget exception.

59.29 **EFFECTIVE DATE.** This section is effective the day following final enactment.

60.1 Sec. 46. **CONSUMER-DIRECTED COMMUNITY SUPPORTS REVISED BUDGET**
60.2 **METHODOLOGY REPORT.**

60.3 (a) The commissioner of human services, in consultation with stakeholders and others
60.4 including representatives of lead agencies, home and community-based services waiver
60.5 participants using consumer-directed community supports, advocacy groups, state agencies,
60.6 the Institute on Community Integration at the University of Minnesota, and service and
60.7 financial management providers, shall develop a revised consumer-directed community
60.8 supports budget methodology. The new methodology shall be based on (1) the costs of
60.9 providing services as reflected by the wage and other relevant components incorporated in
60.10 the disability waiver rate formulas under Minnesota Statutes, chapter 256B, and (2)
60.11 state-to-county waiver-funding methodologies. The new methodology should develop
60.12 individual consumer-directed community supports budgets comparable to those provided
60.13 for similar needs individuals if paying for non-consumer-directed community supports
60.14 waiver services.

60.15 (b) By December 15, 2018, the commissioner shall report a revised consumer-directed
60.16 community supports budget methodology, including proposed legislation and funding
60.17 necessary to implement the new methodology, to the chairs and ranking minority members
60.18 of the house of representatives and senate committees with jurisdiction over health and
60.19 human services.

60.20 **EFFECTIVE DATE.** This section is effective the day following final enactment.

60.21 Sec. 47. **FEDERAL WAIVER AMENDMENTS.**

60.22 The commissioner of human services shall submit necessary waiver amendments to the
60.23 Centers for Medicare and Medicaid Services to add employment exploration services,
60.24 employment development services, and employment support services to the home and
60.25 community-based services waivers authorized under Minnesota Statutes, sections 256B.092
60.26 and 256B.49. The commissioner shall also submit necessary waiver amendments to remove
60.27 community-based employment services from day training and habilitation and prevocational
60.28 services. The commissioner shall submit all necessary waiver amendments by October 1,
60.29 2017.

60.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.

61.1 Sec. 48. **TRANSPORTATION STUDY.**

61.2 The commissioner of human services, with cooperation from lead agencies and in
 61.3 consultation with stakeholders, shall conduct a study to identify opportunities to increase
 61.4 access to transportation services for an individual who receives home and community-based
 61.5 services. The commissioner shall submit a report with recommendations to the chairs and
 61.6 ranking minority members of the legislative committees with jurisdiction over human
 61.7 services by January 15, 2019. The report shall:

61.8 (1) study all aspects of the current transportation service network, including the fleet
 61.9 available, the different rate-setting methods currently used, methods that an individual uses
 61.10 to access transportation, and the diversity of available provider agencies;

61.11 (2) identify current barriers for an individual accessing transportation and for a provider
 61.12 providing waiver services transportation in the marketplace;

61.13 (3) identify efficiencies and collaboration opportunities to increase available
 61.14 transportation, including transportation funded by medical assistance, and available regional
 61.15 transportation and transit options;

61.16 (4) study transportation solutions in other states for delivering home and community-based
 61.17 services;

61.18 (5) study provider costs required to administer transportation services;

61.19 (6) make recommendations for coordinating and increasing transportation accessibility
 61.20 across the state; and

61.21 (7) make recommendations for the rate setting of waived transportation.

61.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

61.23 Sec. 49. **DIRECTION TO COMMISSIONER; TELECOMMUNICATION**
 61.24 **EQUIPMENT PROGRAM.**

61.25 The commissioner of human services shall work in consultation with the Commission
 61.26 of Deaf, Deafblind, and Hard-of-Hearing Minnesotans to provide recommendations by
 61.27 January 15, 2018, to the chairs and ranking minority members of the house of representatives
 61.28 and senate committees with jurisdiction over human services to modernize the
 61.29 telecommunication equipment program. The recommendations must address:

61.30 (1) types of equipment and supports the program should provide to ensure people with
 61.31 communication difficulties have equitable access to telecommunications services;

62.1 (2) additional services the program should provide, such as education about technology
62.2 options that can improve a person's access to telecommunications services; and

62.3 (3) how the current program's service delivery structure might be improved to better
62.4 meet the needs of people with communication disabilities.

62.5 The commissioner shall also provide draft legislative language to accomplish the
62.6 recommendations. Final recommendations, the final report, and draft legislative language
62.7 must be approved by both the commissioner and the chair of the Commission of Deaf,
62.8 Deafblind, and Hard-of-Hearing Minnesotans.

62.9 **Sec. 50. DIRECTION TO COMMISSIONER; BILLING FOR MENTAL HEALTH**
62.10 **SERVICES.**

62.11 By January 1, 2018, the commissioner of human services shall report to the chairs and
62.12 ranking minority members of the house of representatives and senate committees with
62.13 jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the
62.14 Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health
62.15 services.

62.16 **Sec. 51. DIRECTION TO COMMISSIONER; MnCHOICES ASSESSMENT TOOL.**

62.17 The commissioner of human services shall work with lead agencies responsible for
62.18 conducting long-term consultation services under Minnesota Statutes, section 256B.0911,
62.19 to modify the MnCHOICES assessment tool and related policies to:

62.20 (1) reduce assessment times;

62.21 (2) create efficiencies within the tool and within practice and policy for conducting
62.22 assessments and support planning;

62.23 (3) implement policy changes reducing the frequency and depth of assessment and
62.24 reassessment, while ensuring federal compliance with medical assistance and disability
62.25 waiver eligibility requirements; and

62.26 (4) evaluate alternative payment methods.

62.27 **Sec. 52. RANDOM MOMENT TIME STUDY EVALUATION REQUIRED.**

62.28 The commissioner of human services shall evaluate the random moment time study
62.29 methodology for reimbursement of costs associated with county duties required under
62.30 Minnesota Statutes, section 256B.0911. The study must determine whether random moment
62.31 is efficient and effective in supporting functions of assessment and support planning and

63.1 the purpose under Minnesota Statutes, section 256B.0911, subdivision 1. The commissioner
 63.2 shall submit a report to the chairs and ranking minority members of the house of
 63.3 representatives and senate committees with jurisdiction over health and human services by
 63.4 January 15, 2019. The report must provide recommendations for changes to payment
 63.5 methodologies and functions related to assessment, eligibility determination, and support
 63.6 planning.

63.7 Sec. 53. **REPEALER.**

63.8 (a) Minnesota Statutes 2016, sections 144A.351, subdivision 2; 256C.23, subdivision
 63.9 3; 256C.233, subdivision 4; and 256C.25, subdivisions 1 and 2, are repealed.

63.10 (b) Minnesota Statutes 2016, section 256B.4914, subdivision 16, is repealed effective
 63.11 January 1, 2018.

63.12 (c) Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter
 63.13 312, article 27, section 72, Laws 2015, chapter 71, article 7, section 58, Laws 2016, chapter
 63.14 144, section 1; and Laws 2015, chapter 71, article 7, section 54, are repealed upon the
 63.15 effective date of section 44.

63.16 **ARTICLE 2**

63.17 **HOUSING**

63.18 Section 1. Minnesota Statutes 2016, section 144D.04, subdivision 2, is amended to read:

63.19 Subd. 2. **Contents of contract.** A housing with services contract, which need not be
 63.20 entitled as such to comply with this section, shall include at least the following elements in
 63.21 itself or through supporting documents or attachments:

63.22 (1) the name, street address, and mailing address of the establishment;

63.23 (2) the name and mailing address of the owner or owners of the establishment and, if
 63.24 the owner or owners is not a natural person, identification of the type of business entity of
 63.25 the owner or owners;

63.26 (3) the name and mailing address of the managing agent, through management agreement
 63.27 or lease agreement, of the establishment, if different from the owner or owners;

63.28 (4) the name and address of at least one natural person who is authorized to accept service
 63.29 of process on behalf of the owner or owners and managing agent;

64.1 (5) a statement describing the registration and licensure status of the establishment and
64.2 any provider providing health-related or supportive services under an arrangement with the
64.3 establishment;

64.4 (6) the term of the contract;

64.5 (7) a description of the services to be provided to the resident in the base rate to be paid
64.6 by resident, including a delineation of the portion of the base rate that constitutes rent and
64.7 a delineation of charges for each service included in the base rate;

64.8 (8) a description of any additional services, including home care services, available for
64.9 an additional fee from the establishment directly or through arrangements with the
64.10 establishment, and a schedule of fees charged for these services;

64.11 (9) a description of the process through which the contract may be modified, amended,
64.12 or terminated, including whether a move to a different room or sharing a room would be
64.13 required in the event that the tenant can no longer pay the current rent;

64.14 (10) a description of the establishment's complaint resolution process available to residents
64.15 including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;

64.16 (11) the resident's designated representative, if any;

64.17 (12) the establishment's referral procedures if the contract is terminated;

64.18 (13) requirements of residency used by the establishment to determine who may reside
64.19 or continue to reside in the housing with services establishment;

64.20 (14) billing and payment procedures and requirements;

64.21 (15) a statement regarding the ability of ~~residents~~ a resident to receive services from
64.22 service providers with whom the establishment does not have an arrangement;

64.23 (16) a statement regarding the availability of public funds for payment for residence or
64.24 services in the establishment; and

64.25 (17) a statement regarding the availability of and contact information for long-term care
64.26 consultation services under section 256B.0911 in the county in which the establishment is
64.27 located.

64.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

65.1 Sec. 2. Minnesota Statutes 2016, section 144D.04, is amended by adding a subdivision to
65.2 read:

65.3 Subd. 2a. **Additional contract requirements.** (a) For a resident receiving one or more
65.4 health-related services from the establishment's arranged home care provider, as defined in
65.5 section 144D.01, subdivision 6, the contract must include the requirements in paragraph
65.6 (b). A restriction of a resident's rights under this subdivision is allowed only if determined
65.7 necessary for health and safety reasons identified by the home care provider's registered
65.8 nurse in an initial assessment or reassessment, as defined under section 144A.4791,
65.9 subdivision 8, and documented in the written service plan under section 144A.4791,
65.10 subdivision 9. Any restrictions of those rights for people served under sections 256B.0915
65.11 and 256B.49 must be documented in the resident's coordinated service and support plan
65.12 (CSSP), as defined under sections 256B.0915, subdivision 6 and 256B.49, subdivision 15.

65.13 (b) The contract must include a statement:

65.14 (1) regarding the ability of a resident to furnish and decorate the resident's unit within
65.15 the terms of the lease;

65.16 (2) regarding the resident's right to access food at any time;

65.17 (3) regarding a resident's right to choose the resident's visitors and times of visits;

65.18 (4) regarding the resident's right to choose a roommate if sharing a unit; and

65.19 (5) notifying the resident of the resident's right to have and use a lockable door to the
65.20 resident's unit. The landlord shall provide the locks on the unit. Only a staff member with
65.21 a specific need to enter the unit shall have keys, and advance notice must be given to the
65.22 resident before entrance, when possible.

65.23 **EFFECTIVE DATE.** This section is effective the day following final enactment.

65.24 Sec. 3. Minnesota Statutes 2016, section 245A.03, subdivision 7, is amended to read:

65.25 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
65.26 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
65.27 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
65.28 for a physical location that will not be the primary residence of the license holder for the
65.29 entire period of licensure. If a license is issued during this moratorium, and the license
65.30 holder changes the license holder's primary residence away from the physical location of
65.31 the foster care license, the commissioner shall revoke the license according to section

66.1 245A.07. The commissioner shall not issue an initial license for a community residential
66.2 setting licensed under chapter 245D. Exceptions to the moratorium include:

66.3 (1) foster care settings that are required to be registered under chapter 144D;

66.4 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
66.5 community residential setting licenses replacing adult foster care licenses in existence on
66.6 December 31, 2013, and determined to be needed by the commissioner under paragraph
66.7 (b);

66.8 (3) new foster care licenses or community residential setting licenses determined to be
66.9 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
66.10 or regional treatment center; restructuring of state-operated services that limits the capacity
66.11 of state-operated facilities; or allowing movement to the community for people who no
66.12 longer require the level of care provided in state-operated facilities as provided under section
66.13 256B.092, subdivision 13, or 256B.49, subdivision 24;

66.14 (4) new foster care licenses or community residential setting licenses determined to be
66.15 needed by the commissioner under paragraph (b) for persons requiring hospital level care;
66.16 ~~or~~

66.17 (5) new foster care licenses or community residential setting licenses determined to be
66.18 needed by the commissioner for the transition of people from personal care assistance to
66.19 the home and community-based services. When approving an exception under this paragraph,
66.20 the commissioner shall consider the resource need determination process in paragraph (h),
66.21 the availability of foster care licensed beds in the geographic area in which the licensee
66.22 seeks to operate, the results of a person's choices during their annual assessment and service
66.23 plan review, and the recommendation of the local county board. The determination by the
66.24 commissioner is final and not subject to appeal;

66.25 (6) new foster care licenses or community residential setting licenses determined to be
66.26 needed by the commissioner for the transition of people from the residential care waiver
66.27 services to foster care services. This exception applies only when:

66.28 (i) the person's case manager provided the person with information about the choice of
66.29 service, service provider, and location of service to help the person make an informed choice;
66.30 and

66.31 (ii) the person's foster care services are less than or equal to the cost of the person's
66.32 services delivered in the residential care waiver service setting as determined by the lead
66.33 agency; or

67.1 (7) new foster care licenses or community residential setting licenses for people receiving
67.2 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
67.3 for which a license is required. This exception does not apply to people living in their own
67.4 home. For purposes of this clause, there is a presumption that a foster care or community
67.5 residential setting license is required for services provided to three or more people in a
67.6 dwelling unit when the setting is controlled by the provider. A license holder subject to this
67.7 exception may rebut the presumption that a license is required by seeking a reconsideration
67.8 of the commissioner's determination. The commissioner's disposition of a request for
67.9 reconsideration is final and not subject to appeal under chapter 14. The exception is available
67.10 until June 30, 2018. This exception is available when:

67.11 (i) the person's case manager provided the person with information about the choice of
67.12 service, service provider, and location of service, including in the person's home, to help
67.13 the person make an informed choice; and

67.14 (ii) the person's services provided in the licensed foster care or community residential
67.15 setting are less than or equal to the cost of the person's services delivered in the unlicensed
67.16 setting as determined by the lead agency.

67.17 (b) The commissioner shall determine the need for newly licensed foster care homes or
67.18 community residential settings as defined under this subdivision. As part of the determination,
67.19 the commissioner shall consider the availability of foster care capacity in the area in which
67.20 the licensee seeks to operate, and the recommendation of the local county board. The
67.21 determination by the commissioner must be final. A determination of need is not required
67.22 for a change in ownership at the same address.

67.23 (c) When an adult resident served by the program moves out of a foster home that is not
67.24 the primary residence of the license holder according to section 256B.49, subdivision 15,
67.25 paragraph (f), or the adult community residential setting, the county shall immediately
67.26 inform the Department of Human Services Licensing Division. The department ~~shall~~ may
67.27 ~~decrease the statewide licensed capacity for adult foster care settings where the physical~~
67.28 ~~location is not the primary residence of the license holder, or for adult community residential~~
67.29 ~~settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the~~
67.30 ~~savings required by reductions in licensed bed capacity under Laws 2011, First Special~~
67.31 ~~Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term~~
67.32 ~~care residential services capacity within budgetary limits. Implementation of the statewide~~
67.33 ~~licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense~~
67.34 ~~up to 128 beds by June 30, 2014, using the needs determination process. Prior to any~~
67.35 ~~involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies~~

68.1 ~~and license holders to determine which adult foster care settings, where the physical location~~
68.2 ~~is not the primary residence of the license holder, or community residential settings, are~~
68.3 ~~licensed for up to five beds, but have operated at less than full capacity for 12 or more~~
68.4 ~~months as of March 1, 2014. The settings that meet these criteria must be the first to be~~
68.5 ~~considered for an involuntary decrease in statewide licensed capacity, up to a maximum of~~
68.6 ~~35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall~~
68.7 ~~prioritize the selection of those beds to be closed based on the length of time the beds have~~
68.8 ~~been vacant. The longer a bed has been vacant, the higher priority it must be given for~~
68.9 ~~closure. Under this paragraph, the commissioner has the authority to reduce unused licensed~~
68.10 ~~capacity of a current foster care program, or the community residential settings, to accomplish~~
68.11 ~~the consolidation or closure of settings. Under this paragraph, the commissioner has the~~
68.12 ~~authority to manage statewide capacity, including adjusting the capacity available to each~~
68.13 ~~county and adjusting statewide available capacity, to meet the statewide needs identified~~
68.14 ~~through the process in paragraph (e). A decreased licensed capacity according to this~~
68.15 ~~paragraph is not subject to appeal under this chapter.~~

68.16 (d) Residential settings that would otherwise be subject to the decreased license capacity
68.17 established in paragraph (c) shall be exempt if the license holder's beds are occupied by
68.18 residents whose primary diagnosis is mental illness and the license holder is certified under
68.19 the requirements in subdivision 6a or section 245D.33.

68.20 (e) A resource need determination process, managed at the state level, using the available
68.21 reports required by section 144A.351, and other data and information shall be used to
68.22 determine where the reduced capacity ~~required~~ determined under ~~paragraph (e)~~ section
68.23 256B.493 will be implemented. The commissioner shall consult with the stakeholders
68.24 described in section 144A.351, and employ a variety of methods to improve the state's
68.25 capacity to meet the informed decisions of those people who want to move out of corporate
68.26 foster care or community residential settings, long-term ~~care~~ service needs within budgetary
68.27 limits, including seeking proposals from service providers or lead agencies to change service
68.28 type, capacity, or location to improve services, increase the independence of residents, and
68.29 better meet needs identified by the long-term ~~care~~ services and supports reports and statewide
68.30 data and information. By February 1, 2013, and August 1, 2014, and each following year,
68.31 the commissioner shall provide information and data and targets on ~~the overall~~ capacity of
68.32 licensed long-term ~~care~~ services and supports, actions taken under this subdivision to manage
68.33 statewide long-term ~~care~~ services and supports resources, and any recommendations for
68.34 change to the legislative committees with jurisdiction over health and human services budget.

69.1 (f) At the time of application and reapplication for licensure, the applicant and the license
69.2 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
69.3 required to inform the commissioner whether the physical location where the foster care
69.4 will be provided is or will be the primary residence of the license holder for the entire period
69.5 of licensure. If the primary residence of the applicant or license holder changes, the applicant
69.6 or license holder must notify the commissioner immediately. The commissioner shall print
69.7 on the foster care license certificate whether or not the physical location is the primary
69.8 residence of the license holder.

69.9 (g) License holders of foster care homes identified under paragraph (f) that are not the
69.10 primary residence of the license holder and that also provide services in the foster care home
69.11 that are covered by a federally approved home and community-based services waiver, as
69.12 authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services
69.13 licensing division that the license holder provides or intends to provide these waiver-funded
69.14 services.

69.15 (h) The commissioner may adjust capacity to address needs identified in section
69.16 144A.351. Under this authority, the commissioner may approve new licensed settings or
69.17 delicense existing settings. Delicensing of settings will be accomplished through a process
69.18 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
69.19 information and data on capacity of licensed long-term services and supports, actions taken
69.20 under the subdivision to manage statewide long-term services and supports resources, and
69.21 any recommendations for change to the legislative committees with jurisdiction over the
69.22 health and human services budget.

69.23 (i) The commissioner must notify a license holder when its corporate foster care or
69.24 community residential setting licensed beds are reduced under this section. The notice of
69.25 reduction of licensed beds must be in writing and delivered to the license holder by certified
69.26 mail or personal service. The notice must state why the licensed beds are reduced and must
69.27 inform the license holder of its right to request reconsideration by the commissioner. The
69.28 license holder's request for reconsideration must be in writing. If mailed, the request for
69.29 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
69.30 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
69.31 reconsideration is made by personal service, it must be received by the commissioner within
69.32 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

69.33 (j) The commissioner shall not issue an initial license for children's residential treatment
69.34 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
69.35 for a program that Centers for Medicare and Medicaid Services would consider an institution

70.1 for mental diseases. Facilities that serve only private pay clients are exempt from the
 70.2 moratorium described in this paragraph. The commissioner has the authority to manage
 70.3 existing statewide capacity for children's residential treatment services subject to the
 70.4 moratorium under this paragraph and may issue an initial license for such facilities if the
 70.5 initial license would not increase the statewide capacity for children's residential treatment
 70.6 services subject to the moratorium under this paragraph.

70.7 Sec. 4. Minnesota Statutes 2016, section 245A.04, subdivision 14, is amended to read:

70.8 Subd. 14. **Policies and procedures for program administration required and**
 70.9 **enforceable.** (a) The license holder shall develop program policies and procedures necessary
 70.10 to maintain compliance with licensing requirements under Minnesota Statutes and Minnesota
 70.11 Rules.

70.12 (b) The license holder shall:

70.13 (1) provide training to program staff related to their duties in implementing the program's
 70.14 policies and procedures developed under paragraph (a);

70.15 (2) document the provision of this training; and

70.16 (3) monitor implementation of policies and procedures by program staff.

70.17 (c) The license holder shall keep program policies and procedures readily accessible to
 70.18 staff and index the policies and procedures with a table of contents or another method
 70.19 approved by the commissioner.

70.20 (d) An adult foster care license holder that provides foster care services to a resident
 70.21 under section 256B.0915 must annually provide a copy of the resident termination policy
 70.22 under section 245A.11, subdivision 11, to a resident covered by the policy.

70.23 Sec. 5. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to
 70.24 read:

70.25 Subd. 9. **Adult foster care bedrooms.** (a) A resident receiving services must have a
 70.26 choice of roommate. Each roommate must consent in writing to sharing a bedroom with
 70.27 one another. The license holder is responsible for notifying a resident of the resident's right
 70.28 to request a change of roommate.

70.29 (b) The license holder must provide a lock for each resident's bedroom door, unless
 70.30 otherwise indicated for the resident's health, safety, or well-being. A restriction on the use
 70.31 of the lock must be documented and justified in the resident's individual abuse prevention

71.1 plan required by sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision
 71.2 14. For a resident served under section 256B.0915, the case manager must be part of the
 71.3 interdisciplinary team under section 245A.65, subdivision 2, paragraph (b).

71.4 **EFFECTIVE DATE.** This section is effective the day following final enactment.

71.5 Sec. 6. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to
 71.6 read:

71.7 Subd. 10. **Adult foster care resident rights.** (a) The license holder shall ensure that a
 71.8 resident and a resident's legal representative are given, at admission:

71.9 (1) an explanation and copy of the resident's rights specified in paragraph (b);

71.10 (2) a written summary of the Vulnerable Adults Protection Act prepared by the
 71.11 department; and

71.12 (3) the name, address, and telephone number of the local agency to which a resident or
 71.13 a resident's legal representative may submit an oral or written complaint.

71.14 (b) Adult foster care resident rights include the right to:

71.15 (1) have daily, private access to and use of a non-coin-operated telephone for local and
 71.16 long-distance telephone calls made collect or paid for by the resident;

71.17 (2) receive and send, without interference, uncensored, unopened mail or electronic
 71.18 correspondence or communication;

71.19 (3) have use of and free access to common areas in the residence and the freedom to
 71.20 come and go from the residence at will;

71.21 (4) have privacy for visits with the resident's spouse, next of kin, legal counsel, religious
 71.22 adviser, or others, according to section 363A.09 of the Human Rights Act, including privacy
 71.23 in the resident's bedroom;

71.24 (5) keep, use, and access the resident's personal clothing and possessions as space permits,
 71.25 unless this right infringes on the health, safety, or rights of another resident or household
 71.26 member, including the right to access the resident's personal possessions at any time;

71.27 (6) choose the resident's visitors and time of visits and participate in activities of
 71.28 commercial, religious, political, and community groups without interference if the activities
 71.29 do not infringe on the rights of another resident or household member;

71.30 (7) if married, privacy for visits by the resident's spouse, and, if both spouses are residents
 71.31 of the adult foster home, the residents have the right to share a bedroom and bed;

- 72.1 (8) privacy, including use of the lock on the resident's bedroom door or unit door. A
72.2 resident's privacy must be respected by license holders, caregivers, household members,
72.3 and volunteers by knocking on the door of a resident's bedroom or bathroom and seeking
72.4 consent before entering, except in an emergency;
- 72.5 (9) furnish and decorate the resident's bedroom or living unit;
- 72.6 (10) engage in chosen activities and have an individual schedule supported by the license
72.7 holder that meets the resident's preferences;
- 72.8 (11) freedom and support to access food at any time;
- 72.9 (12) have personal, financial, service, health, and medical information kept private, and
72.10 be advised of disclosure of this information by the license holder;
- 72.11 (13) access records and recorded information about the resident according to applicable
72.12 state and federal law, regulation, or rule;
- 72.13 (14) be free from maltreatment;
- 72.14 (15) be treated with courtesy and respect and receive respectful treatment of the resident's
72.15 property;
- 72.16 (16) reasonable observance of cultural and ethnic practice and religion;
- 72.17 (17) be free from bias and harassment regarding race, gender, age, disability, spirituality,
72.18 and sexual orientation;
- 72.19 (18) be informed of and use the license holder's grievance policy and procedures,
72.20 including how to contact the highest level of authority in the program;
- 72.21 (19) assert the resident's rights personally, or have the rights asserted by the resident's
72.22 family, authorized representative, or legal representative, without retaliation; and
- 72.23 (20) give or withhold written informed consent to participate in any research or
72.24 experimental treatment.
- 72.25 (c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8),
72.26 (10), and (11), is allowed only if determined necessary to ensure the health, safety, and
72.27 well-being of the resident. Any restriction of a resident's right must be documented and
72.28 justified in the resident's individual abuse prevention plan required by sections 245A.65,
72.29 subdivision 2, paragraph (b) and 626.557, subdivision 14. For a resident served under section
72.30 256B.0915, the case manager must be part of the interdisciplinary team under section
72.31 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the least

73.1 restrictive manner necessary to protect the resident and provide support to reduce or eliminate
 73.2 the need for the restriction.

73.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

73.4 Sec. 7. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to
 73.5 read:

73.6 **Subd. 11. Adult foster care service termination for elderly waiver participants.** (a)
 73.7 This subdivision applies to foster care services for a resident served under section 256B.0915.

73.8 (b) The foster care license holder must establish policies and procedures for service
 73.9 termination that promote continuity of care and service coordination with the resident and
 73.10 the case manager and with another licensed caregiver, if any, who also provides support to
 73.11 the resident. The policy must include the requirements specified in paragraphs (c) to (h).

73.12 (c) The license holder must allow a resident to remain in the program and cannot terminate
 73.13 services unless:

73.14 (1) the termination is necessary for the resident's health, safety, and well-being and the
 73.15 resident's needs cannot be met in the facility;

73.16 (2) the safety of the resident or another resident in the program is endangered and positive
 73.17 support strategies were attempted and have not achieved and effectively maintained safety
 73.18 for the resident or another resident in the program;

73.19 (3) the health, safety, and well-being of the resident or another resident in the program
 73.20 would otherwise be endangered;

73.21 (4) the program was not paid for services;

73.22 (5) the program ceases to operate; or

73.23 (6) the resident was terminated by the lead agency from waiver eligibility.

73.24 (d) Before giving notice of service termination, the license holder must document the
 73.25 action taken to minimize or eliminate the need for termination. The action taken by the
 73.26 license holder must include, at a minimum:

73.27 (1) consultation with the resident's interdisciplinary team to identify and resolve issues
 73.28 leading to a notice of service termination; and

73.29 (2) a request to the case manager or other professional consultation or intervention
 73.30 services to support the resident in the program. This requirement does not apply to a notice
 73.31 of service termination issued under paragraph (c), clause (4) or (5).

74.1 (e) If, based on the best interests of the resident, the circumstances at the time of notice
 74.2 were such that the license holder was unable to take the action specified in paragraph (d),
 74.3 the license holder must document the specific circumstances and the reason the license
 74.4 holder was unable to take the action.

74.5 (f) The license holder must notify the resident or the resident's legal representative and
 74.6 the case manager in writing of the intended service termination. The notice must include:

74.7 (1) the reason for the action;

74.8 (2) except for service termination under paragraph (c), clause (4) or (5), a summary of
 74.9 the action taken to minimize or eliminate the need for termination and the reason the action
 74.10 failed to prevent the termination;

74.11 (3) the resident's right to appeal the service termination under section 256.045, subdivision
 74.12 3, paragraph (a); and

74.13 (4) the resident's right to seek a temporary order staying the service termination according
 74.14 to the procedures in section 256.045, subdivision 4a, or subdivision 6, paragraph (c).

74.15 (g) Notice of the proposed service termination must be given at least 30 days before
 74.16 terminating a resident's service.

74.17 (h) After the resident receives the notice of service termination and before the services
 74.18 are terminated, the license holder must:

74.19 (1) work with the support team or expanded support team to develop reasonable
 74.20 alternatives to support continuity of care and to protect the resident;

74.21 (2) provide information requested by the resident or case manager; and

74.22 (3) maintain information about the service termination, including the written notice of
 74.23 service termination, in the resident's record.

74.24 **EFFECTIVE DATE.** This section is effective the day following final enactment.

74.25 Sec. 8. Minnesota Statutes 2016, section 245D.04, subdivision 3, is amended to read:

74.26 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the
 74.27 right to:

74.28 (1) have personal, financial, service, health, and medical information kept private, and
 74.29 be advised of disclosure of this information by the license holder;

74.30 (2) access records and recorded information about the person in accordance with
 74.31 applicable state and federal law, regulation, or rule;

- 75.1 (3) be free from maltreatment;
- 75.2 (4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited
75.3 procedure identified in section 245D.06, subdivision 5, or successor provisions, except for:
75.4 (i) emergency use of manual restraint to protect the person from imminent danger to self
75.5 or others according to the requirements in section 245D.061 or successor provisions; or (ii)
75.6 the use of safety interventions as part of a positive support transition plan under section
75.7 245D.06, subdivision 8, or successor provisions;
- 75.8 (5) receive services in a clean and safe environment when the license holder is the owner,
75.9 lessor, or tenant of the service site;
- 75.10 (6) be treated with courtesy and respect and receive respectful treatment of the person's
75.11 property;
- 75.12 (7) reasonable observance of cultural and ethnic practice and religion;
- 75.13 (8) be free from bias and harassment regarding race, gender, age, disability, spirituality,
75.14 and sexual orientation;
- 75.15 (9) be informed of and use the license holder's grievance policy and procedures, including
75.16 knowing how to contact persons responsible for addressing problems and to appeal under
75.17 section 256.045;
- 75.18 (10) know the name, telephone number, and the Web site, e-mail, and street addresses
75.19 of protection and advocacy services, including the appropriate state-appointed ombudsman,
75.20 and a brief description of how to file a complaint with these offices;
- 75.21 (11) assert these rights personally, or have them asserted by the person's family,
75.22 authorized representative, or legal representative, without retaliation;
- 75.23 (12) give or withhold written informed consent to participate in any research or
75.24 experimental treatment;
- 75.25 (13) associate with other persons of the person's choice;
- 75.26 (14) personal privacy, including the right to use the lock on the person's bedroom or unit
75.27 door; and
- 75.28 (15) engage in chosen activities; and
- 75.29 (16) access to the person's personal possessions at any time, including financial resources.

76.1 (b) For a person residing in a residential site licensed according to chapter 245A, or
 76.2 where the license holder is the owner, lessor, or tenant of the residential service site,
 76.3 protection-related rights also include the right to:

76.4 (1) have daily, private access to and use of a non-coin-operated telephone for local calls
 76.5 and long-distance calls made collect or paid for by the person;

76.6 (2) receive and send, without interference, uncensored, unopened mail or electronic
 76.7 correspondence or communication;

76.8 (3) have use of and free access to common areas in the residence and the freedom to
 76.9 come and go from the residence at will; ~~and~~

76.10 (4) choose the person's visitors and time of visits and have privacy for visits with the
 76.11 person's spouse, next of kin, legal counsel, religious ~~advisor~~ adviser, or others, in accordance
 76.12 with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;₂

76.13 (5) the freedom and support to access food at any time;

76.14 (6) the freedom to furnish and decorate the person's bedroom or living unit;

76.15 (7) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling
 76.16 paint, mold, vermin, and insects;

76.17 (8) a setting that is free from hazards that threaten the person's health or safety;

76.18 (9) a setting that meets state and local building and zoning definitions of a dwelling unit
 76.19 in a residential occupancy; and

76.20 (10) have access to potable water and three nutritionally balanced meals and nutritious
 76.21 snacks between meals each day.

76.22 (c) Restriction of a person's rights under paragraph (a), clauses (13) to ~~(15)~~ (16), or
 76.23 paragraph (b) is allowed only if determined necessary to ensure the health, safety, and
 76.24 well-being of the person. Any restriction of those rights must be documented in the person's
 76.25 coordinated service and support plan or coordinated service and support plan addendum.
 76.26 The restriction must be implemented in the least restrictive alternative manner necessary
 76.27 to protect the person and provide support to reduce or eliminate the need for the restriction
 76.28 in the most integrated setting and inclusive manner. The documentation must include the
 76.29 following information:

76.30 (1) the justification for the restriction based on an assessment of the person's vulnerability
 76.31 related to exercising the right without restriction;

76.32 (2) the objective measures set as conditions for ending the restriction;

77.1 (3) a schedule for reviewing the need for the restriction based on the conditions for
77.2 ending the restriction to occur semiannually from the date of initial approval, at a minimum,
77.3 or more frequently if requested by the person, the person's legal representative, if any, and
77.4 case manager; and

77.5 (4) signed and dated approval for the restriction from the person, or the person's legal
77.6 representative, if any. A restriction may be implemented only when the required approval
77.7 has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the
77.8 right must be immediately and fully restored.

77.9 **EFFECTIVE DATE.** This section is effective the day following final enactment.

77.10 Sec. 9. Minnesota Statutes 2016, section 245D.071, subdivision 3, is amended to read:

77.11 Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation
77.12 the license holder must complete a preliminary coordinated service and support plan
77.13 addendum based on the coordinated service and support plan.

77.14 (b) Within the scope of services, the license holder must, at a minimum, complete
77.15 assessments in the following areas before the 45-day planning meeting:

77.16 (1) the person's ability to self-manage health and medical needs to maintain or improve
77.17 physical, mental, and emotional well-being, including, when applicable, allergies, seizures,
77.18 choking, special dietary needs, chronic medical conditions, self-administration of medication
77.19 or treatment orders, preventative screening, and medical and dental appointments;

77.20 (2) the person's ability to self-manage personal safety to avoid injury or accident in the
77.21 service setting, including, when applicable, risk of falling, mobility, regulating water
77.22 temperature, community survival skills, water safety skills, and sensory disabilities; and

77.23 (3) the person's ability to self-manage symptoms or behavior that may otherwise result
77.24 in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension
77.25 or termination of services by the license holder, or other symptoms or behaviors that may
77.26 jeopardize the health and welfare of the person or others.

77.27 Assessments must produce information about the person that describes the person's overall
77.28 strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be
77.29 based on the person's status within the last 12 months at the time of service initiation.

77.30 Assessments based on older information must be documented and justified. Assessments
77.31 must be conducted annually at a minimum or within 30 days of a written request from the
77.32 person or the person's legal representative or case manager. The results must be reviewed
77.33 by the support team or expanded support team as part of a service plan review.

78.1 (c) Within 45 days of service initiation, the license holder must meet with the person,
78.2 the person's legal representative, the case manager, and other members of the support team
78.3 or expanded support team to determine the following based on information obtained from
78.4 the assessments identified in paragraph (b), the person's identified needs in the coordinated
78.5 service and support plan, and the requirements in subdivision 4 and section 245D.07,
78.6 subdivision 1a:

78.7 (1) the scope of the services to be provided to support the person's daily needs and
78.8 activities;

78.9 (2) the person's desired outcomes and the supports necessary to accomplish the person's
78.10 desired outcomes;

78.11 (3) the person's preferences for how services and supports are provided, including how
78.12 the provider will support the person to have control of the person's schedule;

78.13 (4) whether the current service setting is the most integrated setting available and
78.14 appropriate for the person; and

78.15 (5) how services must be coordinated across other providers licensed under this chapter
78.16 serving the person and members of the support team or expanded support team to ensure
78.17 continuity of care and coordination of services for the person.

78.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.

78.19 Sec. 10. Minnesota Statutes 2016, section 245D.11, subdivision 4, is amended to read:

78.20 Subd. 4. **Admission criteria.** The license holder must establish policies and procedures
78.21 that promote continuity of care by ensuring that admission or service initiation criteria:

78.22 (1) is consistent with the service-related rights identified in section 245D.04, subdivisions
78.23 2, clauses (4) to (7), and 3, clause (8);

78.24 (2) identifies the criteria to be applied in determining whether the license holder can
78.25 develop services to meet the needs specified in the person's coordinated service and support
78.26 plan;

78.27 (3) requires a license holder providing services in a health care facility to comply with
78.28 the requirements in section 243.166, subdivision 4b, to provide notification to residents
78.29 when a registered predatory offender is admitted into the program or to a potential admission
78.30 when the facility was already serving a registered predatory offender. For purposes of this
78.31 clause, "health care facility" means a facility licensed by the commissioner as a residential

79.1 facility under chapter 245A to provide adult foster care or residential services to persons
79.2 with disabilities; ~~and~~

79.3 (4) requires that when a person or the person's legal representative requests services
79.4 from the license holder, a refusal to admit the person must be based on an evaluation of the
79.5 person's assessed needs and the license holder's lack of capacity to meet the needs of the
79.6 person. The license holder must not refuse to admit a person based solely on the type of
79.7 residential services the person is receiving, or solely on the person's severity of disability,
79.8 orthopedic or neurological handicaps, sight or hearing impairments, lack of communication
79.9 skills, physical disabilities, toilet habits, behavioral disorders, or past failure to make progress.
79.10 Documentation of the basis for refusal must be provided to the person or the person's legal
79.11 representative and case manager upon request; and

79.12 (5) requires the person or the person's legal representative and license holder to sign and
79.13 date the residency agreement when the license holder provides foster care or supported
79.14 living services under section 245D.03, subdivision 1, paragraph (c), clause (3), item (i) or
79.15 (ii), to a person living in a community residential setting defined in section 245D.02,
79.16 subdivision 4a; an adult foster home defined in Minnesota Rules, part 9555.5105, subpart
79.17 5; or a foster family home defined in Minnesota Rules, part 9560.0521, subpart 12. The
79.18 residency agreement must include service termination requirements specified in section
79.19 245D.10, subdivision 3a, paragraphs (b) to (f). The residency agreement must be reviewed
79.20 annually, dated, and signed by the person or the person's legal representative and license
79.21 holder.

79.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

79.23 Sec. 11. Minnesota Statutes 2016, section 245D.24, subdivision 3, is amended to read:

79.24 Subd. 3. **Bedrooms.** (a) ~~People~~ Each person receiving services must have a choice of
79.25 roommate and must mutually consent, in writing, to sharing a bedroom with one another.
79.26 No more than two people receiving services may share one bedroom.

79.27 (b) A single occupancy bedroom must have at least 80 square feet of floor space with a
79.28 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
79.29 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and other
79.30 habitable rooms by floor-to-ceiling walls containing no openings except doorways and must
79.31 not serve as a corridor to another room used in daily living.

79.32 (c) A person's personal possessions and items for the person's own use are the only items
79.33 permitted to be stored in a person's bedroom.

80.1 (d) Unless otherwise documented through assessment as a safety concern for the person,
80.2 each person must be provided with the following furnishings:

80.3 (1) a separate bed of proper size and height for the convenience and comfort of the
80.4 person, with a clean mattress in good repair;

80.5 (2) clean bedding appropriate for the season for each person;

80.6 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
80.7 possessions and clothing; and

80.8 (4) a mirror for grooming.

80.9 (e) When possible, a person must be allowed to have items of furniture that the person
80.10 personally owns in the bedroom, unless doing so would interfere with safety precautions,
80.11 violate a building or fire code, or interfere with another person's use of the bedroom. A
80.12 person may choose not to have a cabinet, dresser, shelves, or a mirror in the bedroom, as
80.13 otherwise required under paragraph (d), clause (3) or (4). A person may choose to use a
80.14 mattress other than an innerspring mattress and may choose not to have the mattress on a
80.15 mattress frame or support. If a person chooses not to have a piece of required furniture, the
80.16 license holder must document this choice and is not required to provide the item. If a person
80.17 chooses to use a mattress other than an innerspring mattress or chooses not to have a mattress
80.18 frame or support, the license holder must document this choice and allow the alternative
80.19 desired by the person.

80.20 (f) A person must be allowed to bring personal possessions into the bedroom and other
80.21 designated storage space, if such space is available, in the residence. The person must be
80.22 allowed to accumulate possessions to the extent the residence is able to accommodate them,
80.23 unless doing so is contraindicated for the person's physical or mental health, would interfere
80.24 with safety precautions or another person's use of the bedroom, or would violate a building
80.25 or fire code. The license holder must allow for locked storage of personal items. Any
80.26 restriction on the possession or locked storage of personal items, including requiring a
80.27 person to use a lock provided by the license holder, must comply with section 245D.04,
80.28 subdivision 3, paragraph (c), and allow the person to be present if and when the license
80.29 holder opens the lock.

80.30 (g) A person must be allowed to lock the person's bedroom door. The license holder
80.31 must document and assess the physical plant and the environment, and the population served,
80.32 and identify the risk factors that require using locked doors, and the specific action taken
80.33 to minimize the safety risk to a person receiving services at the site.

81.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

81.2 Sec. 12. Minnesota Statutes 2016, section 256.045, subdivision 3, is amended to read:

81.3 Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

81.4 (1) any person applying for, receiving or having received public assistance, medical
81.5 care, or a program of social services granted by the state agency or a county agency or the
81.6 federal Food Stamp Act whose application for assistance is denied, not acted upon with
81.7 reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed
81.8 to have been incorrectly paid;

81.9 (2) any patient or relative aggrieved by an order of the commissioner under section
81.10 252.27;

81.11 (3) a party aggrieved by a ruling of a prepaid health plan;

81.12 (4) except as provided under chapter 245C, any individual or facility determined by a
81.13 lead investigative agency to have maltreated a vulnerable adult under section 626.557 after
81.14 they have exercised their right to administrative reconsideration under section 626.557;

81.15 (5) any person whose claim for foster care payment according to a placement of the
81.16 child resulting from a child protection assessment under section 626.556 is denied or not
81.17 acted upon with reasonable promptness, regardless of funding source;

81.18 (6) any person to whom a right of appeal according to this section is given by other
81.19 provision of law;

81.20 (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver
81.21 under section 256B.15;

81.22 (8) an applicant aggrieved by an adverse decision to an application or redetermination
81.23 for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

81.24 (9) except as provided under chapter 245A, an individual or facility determined to have
81.25 maltreated a minor under section 626.556, after the individual or facility has exercised the
81.26 right to administrative reconsideration under section 626.556;

81.27 (10) except as provided under chapter 245C, an individual disqualified under sections
81.28 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23,
81.29 on the basis of serious or recurring maltreatment; a preponderance of the evidence that the
81.30 individual has committed an act or acts that meet the definition of any of the crimes listed
81.31 in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section
81.32 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment

82.1 determination under clause (4) or (9) and a disqualification under this clause in which the
 82.2 basis for a disqualification is serious or recurring maltreatment, shall be consolidated into
 82.3 a single fair hearing. In such cases, the scope of review by the human services judge shall
 82.4 include both the maltreatment determination and the disqualification. The failure to exercise
 82.5 the right to an administrative reconsideration shall not be a bar to a hearing under this section
 82.6 if federal law provides an individual the right to a hearing to dispute a finding of
 82.7 maltreatment;

82.8 (11) any person with an outstanding debt resulting from receipt of public assistance,
 82.9 medical care, or the federal Food Stamp Act who is contesting a setoff claim by the
 82.10 Department of Human Services or a county agency. The scope of the appeal is the validity
 82.11 of the claimant agency's intention to request a setoff of a refund under chapter 270A against
 82.12 the debt;

82.13 (12) a person issued a notice of service termination under section 245D.10, subdivision
 82.14 3a, from residential supports and services as defined in section 245D.03, subdivision 1,
 82.15 paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a; ~~or~~

82.16 (13) an individual disability waiver recipient based on a denial of a request for a rate
 82.17 exception under section 256B.4914; or

82.18 (14) a person issued a notice of service termination under section 245A.11, subdivision
 82.19 11, that is not otherwise subject to appeal under subdivision 4a.

82.20 (b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10),
 82.21 is the only administrative appeal to the final agency determination specifically, including
 82.22 a challenge to the accuracy and completeness of data under section 13.04. Hearings requested
 82.23 under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or
 82.24 after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged
 82.25 to have maltreated a resident prior to October 1, 1995, shall be held as a contested case
 82.26 proceeding under the provisions of chapter 14. Hearings requested under paragraph (a),
 82.27 clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A
 82.28 hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only
 82.29 available when there is no district court action pending. If such action is filed in district
 82.30 court while an administrative review is pending that arises out of some or all of the events
 82.31 or circumstances on which the appeal is based, the administrative review must be suspended
 82.32 until the judicial actions are completed. If the district court proceedings are completed,
 82.33 dismissed, or overturned, the matter may be considered in an administrative hearing.

83.1 (c) For purposes of this section, bargaining unit grievance procedures are not an
83.2 administrative appeal.

83.3 (d) The scope of hearings involving claims to foster care payments under paragraph (a),
83.4 clause (5), shall be limited to the issue of whether the county is legally responsible for a
83.5 child's placement under court order or voluntary placement agreement and, if so, the correct
83.6 amount of foster care payment to be made on the child's behalf and shall not include review
83.7 of the propriety of the county's child protection determination or child placement decision.

83.8 (e) The scope of hearings under paragraph (a), ~~clause~~ clauses (12) and (14), shall be
83.9 limited to whether the proposed termination of services is authorized under section 245D.10,
83.10 subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements
83.11 of section 245D.10, subdivision 3a, ~~paragraph~~ paragraphs (c) to (e), or 245A.11, subdivision
83.12 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of
83.13 termination of services, the scope of the hearing shall also include whether the case
83.14 management provider has finalized arrangements for a residential facility, a program, or
83.15 services that will meet the assessed needs of the recipient by the effective date of the service
83.16 termination.

83.17 (f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor
83.18 under contract with a county agency to provide social services is not a party and may not
83.19 request a hearing under this section, except if assisting a recipient as provided in subdivision
83.20 4.

83.21 (g) An applicant or recipient is not entitled to receive social services beyond the services
83.22 prescribed under chapter 256M or other social services the person is eligible for under state
83.23 law.

83.24 (h) The commissioner may summarily affirm the county or state agency's proposed
83.25 action without a hearing when the sole issue is an automatic change due to a change in state
83.26 or federal law.

83.27 (i) Unless federal or Minnesota law specifies a different time frame in which to file an
83.28 appeal, an individual or organization specified in this section may contest the specified
83.29 action, decision, or final disposition before the state agency by submitting a written request
83.30 for a hearing to the state agency within 30 days after receiving written notice of the action,
83.31 decision, or final disposition, or within 90 days of such written notice if the applicant,
83.32 recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision
83.33 13, why the request was not submitted within the 30-day time limit. The individual filing
83.34 the appeal has the burden of proving good cause by a preponderance of the evidence.

84.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

84.2 Sec. 13. **[256B.051] HOUSING SUPPORT SERVICES.**

84.3 Subdivision 1. **Purpose.** Housing support services are established to provide housing
84.4 support services to an individual with a disability that limits the individual's ability to obtain
84.5 or maintain stable housing. The services support an individual's transition to housing in the
84.6 community and increase long-term stability in housing, to avoid future periods of being at
84.7 risk of homelessness or institutionalization.

84.8 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this
84.9 subdivision have the meanings given.

84.10 (b) "At-risk of homelessness" means (1) an individual that is faced with a set of
84.11 circumstances likely to cause the individual to become homeless, or (2) an individual
84.12 previously homeless, who will be discharged from a correctional, medical, mental health,
84.13 or treatment center, who lacks sufficient resources to pay for housing and does not have a
84.14 permanent place to live.

84.15 (c) "Commissioner" means the commissioner of human services.

84.16 (d) "Homeless" means an individual or family lacking a fixed, adequate nighttime
84.17 residence.

84.18 (e) "Individual with a disability" means:

84.19 (1) an individual who is aged, blind, or disabled as determined by the criteria used by
84.20 the title 11 program of the Social Security Act, United States Code, title 42, section 416,
84.21 paragraph (i), item (1); or

84.22 (2) an individual who meets a category of eligibility under section 256D.05, subdivision
84.23 1, paragraph (a), clauses (1), (3), (5) to (9), or (14).

84.24 (f) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause
84.25 (3), and the Minnesota Security Hospital as defined in section 253.20.

84.26 Subd. 3. **Eligibility.** An individual with a disability is eligible for housing support services
84.27 if the individual:

84.28 (1) is 18 years of age or older;

84.29 (2) is enrolled in medical assistance;

84.30 (3) has an assessment of functional need that determines a need for services due to
84.31 limitations caused by the individual's disability;

85.1 (4) resides in or plans to transition to a community-based setting as defined in Code of
85.2 Federal Regulations, title 42, section 441.301(c); and

85.3 (5) has housing instability evidenced by:

85.4 (i) being homeless or at-risk of homelessness;

85.5 (ii) being in the process of transitioning from, or having transitioned in the past six
85.6 months from, an institution or licensed or registered setting;

85.7 (iii) being eligible for waiver services under section 256B.0915, 256B.092, or 256B.49;

85.8 or

85.9 (iv) having been identified by a long-term care consultation under section 256B.0911
85.10 as at risk of institutionalization.

85.11 Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need
85.12 must be conducted by one of the following methods:

85.13 (1) an assessor according to the criteria established in section 256B.0911, subdivision
85.14 3a, using a format established by the commissioner;

85.15 (2) documented need for services as verified by a professional statement of need as
85.16 defined in section 256I.03, subdivision 12; or

85.17 (3) according to the continuum of care coordinated assessment system established in
85.18 Code of Federal Regulations, title 24, section 578.3, using a format established by the
85.19 commissioner.

85.20 (b) An individual must be reassessed within one year of initial assessment, and annually
85.21 thereafter.

85.22 Subd. 5. **Housing support services.** (a) Housing support services include housing
85.23 transition services and housing and tenancy sustaining services.

85.24 (b) Housing transition services are defined as:

85.25 (1) tenant screening and housing assessment;

85.26 (2) assistance with the housing search and application process;

85.27 (3) identifying resources to cover onetime moving expenses;

85.28 (4) ensuring a new living arrangement is safe and ready for move-in;

85.29 (5) assisting in arranging for and supporting details of a move; and

85.30 (6) developing a housing support crisis plan.

86.1 (c) Housing and tenancy sustaining services include:

86.2 (1) prevention and early identification of behaviors that may jeopardize continued stable
86.3 housing;

86.4 (2) education and training on roles, rights, and responsibilities of the tenant and the
86.5 property manager;

86.6 (3) coaching to develop and maintain key relationships with property managers and
86.7 neighbors;

86.8 (4) advocacy and referral to community resources to prevent eviction when housing is
86.9 at risk;

86.10 (5) assistance with housing recertification process;

86.11 (6) coordination with the tenant to regularly review, update, and modify housing support
86.12 and crisis plan; and

86.13 (7) continuing training on being a good tenant, lease compliance, and household
86.14 management.

86.15 (d) A housing support service may include person-centered planning for people who are
86.16 not eligible to receive person-centered planning through any other service, if the
86.17 person-centered planning is provided by a consultation service provider that is under contract
86.18 with the department and enrolled as a Minnesota health care program.

86.19 Subd. 6. **Provider qualifications and duties.** A provider eligible for reimbursement
86.20 under this section shall:

86.21 (1) enroll as a medical assistance Minnesota health care program provider and meet all
86.22 applicable provider standards and requirements;

86.23 (2) demonstrate compliance with federal and state laws and policies for housing support
86.24 services as determined by the commissioner;

86.25 (3) comply with background study requirements under chapter 245C and maintain
86.26 documentation of background study requests and results; and

86.27 (4) directly provide housing support services and not use a subcontractor or reporting
86.28 agent.

86.29 Subd. 7. **Housing support supplemental service rates.** Supplemental service rates for
86.30 individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph
86.31 (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year

87.1 period. This reduction only applies to supplemental service rates for individuals eligible for
87.2 housing support services under this section.

87.3 **EFFECTIVE DATE.** (a) Subdivisions 1 to 6 are contingent upon federal approval. The
87.4 commissioner of human services shall notify the revisor of statutes when federal approval
87.5 is obtained.

87.6 (b) Subdivision 7 is contingent upon federal approval of subdivisions 1 to 6. The
87.7 commissioner of human services shall notify the revisor of statutes when federal approval
87.8 is obtained.

87.9 Sec. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

87.10 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
87.11 planning, or other assistance intended to support community-based living, including persons
87.12 who need assessment in order to determine waiver or alternative care program eligibility,
87.13 must be visited by a long-term care consultation team within 20 calendar days after the date
87.14 on which an assessment was requested or recommended. Upon statewide implementation
87.15 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
87.16 requesting personal care assistance services and home care nursing. The commissioner shall
87.17 provide at least a 90-day notice to lead agencies prior to the effective date of this requirement.
87.18 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

87.19 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
87.20 assessors to conduct the assessment. For a person with complex health care needs, a public
87.21 health or registered nurse from the team must be consulted.

87.22 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
87.23 be used to complete a comprehensive, person-centered assessment. The assessment must
87.24 include the health, psychological, functional, environmental, and social needs of the
87.25 individual necessary to develop a community support plan that meets the individual's needs
87.26 and preferences.

87.27 (d) The assessment must be conducted in a face-to-face interview with the person being
87.28 assessed and the person's legal representative. At the request of the person, other individuals
87.29 may participate in the assessment to provide information on the needs, strengths, and
87.30 preferences of the person necessary to develop a community support plan that ensures the
87.31 person's health and safety. Except for legal representatives or family members invited by
87.32 the person, persons participating in the assessment may not be a provider of service or have
87.33 any financial interest in the provision of services. For persons who are to be assessed for

88.1 elderly waiver customized living services under section 256B.0915, with the permission of
88.2 the person being assessed or the person's designated or legal representative, the client's
88.3 current or proposed provider of services may submit a copy of the provider's nursing
88.4 assessment or written report outlining its recommendations regarding the client's care needs.
88.5 The person conducting the assessment must notify the provider of the date by which this
88.6 information is to be submitted. This information shall be provided to the person conducting
88.7 the assessment prior to the assessment. For a person who is to be assessed for waiver services
88.8 under section 256B.092 or 256B.49, with the permission of the person being assessed or
88.9 the person's designated legal representative, the person's current provider of services may
88.10 submit a written report outlining recommendations regarding the person's care needs prepared
88.11 by a direct service employee with at least 20 hours of service to that client. The person
88.12 conducting the assessment or reassessment must notify the provider of the date by which
88.13 this information is to be submitted. This information shall be provided to the person
88.14 conducting the assessment and the person or the person's legal representative, and must be
88.15 considered prior to the finalization of the assessment or reassessment.

88.16 (e) The person or the person's legal representative must be provided with a written
88.17 community support plan within 40 calendar days of the assessment visit, regardless of
88.18 whether the individual is eligible for Minnesota health care programs. The written community
88.19 support plan must include:

88.20 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

88.21 (2) the individual's options and choices to meet identified needs, including all available
88.22 options for case management services and providers;

88.23 (3) identification of health and safety risks and how those risks will be addressed,
88.24 including personal risk management strategies;

88.25 (4) referral information; and

88.26 (5) informal caregiver supports, if applicable.

88.27 For a person determined eligible for state plan home care under subdivision 1a, paragraph
88.28 (b), clause (1), the person or person's representative must also receive a copy of the home
88.29 care service plan developed by the certified assessor.

88.30 (f) A person may request assistance in identifying community supports without
88.31 participating in a complete assessment. Upon a request for assistance identifying community
88.32 support, the person must be transferred or referred to long-term care options counseling

89.1 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for
89.2 telephone assistance and follow up.

89.3 (g) The person has the right to make the final decision between institutional placement
89.4 and community placement after the recommendations have been provided, except as provided
89.5 in section 256.975, subdivision 7a, paragraph (d).

89.6 (h) The lead agency must give the person receiving assessment or support planning, or
89.7 the person's legal representative, materials, and forms supplied by the commissioner
89.8 containing the following information:

89.9 (1) written recommendations for community-based services and consumer-directed
89.10 options;

89.11 (2) documentation that the most cost-effective alternatives available were offered to the
89.12 individual. For purposes of this clause, "cost-effective" means community services and
89.13 living arrangements that cost the same as or less than institutional care. For an individual
89.14 found to meet eligibility criteria for home and community-based service programs under
89.15 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
89.16 approved waiver plan for each program;

89.17 (3) the need for and purpose of preadmission screening conducted by long-term care
89.18 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
89.19 nursing facility placement. If the individual selects nursing facility placement, the lead
89.20 agency shall forward information needed to complete the level of care determinations and
89.21 screening for developmental disability and mental illness collected during the assessment
89.22 to the long-term care options counselor using forms provided by the commissioner;

89.23 (4) the role of long-term care consultation assessment and support planning in eligibility
89.24 determination for waiver and alternative care programs, and state plan home care, case
89.25 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
89.26 and (b);

89.27 (5) information about Minnesota health care programs;

89.28 (6) the person's freedom to accept or reject the recommendations of the team;

89.29 (7) the person's right to confidentiality under the Minnesota Government Data Practices
89.30 Act, chapter 13;

89.31 (8) the certified assessor's decision regarding the person's need for institutional level of
89.32 care as determined under criteria established in subdivision 4e and the certified assessor's

90.1 decision regarding eligibility for all services and programs as defined in subdivision 1a,
90.2 paragraphs (a), clause (6), and (b); and

90.3 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
90.4 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
90.5 (8), and (b), and incorporating the decision regarding the need for institutional level of care
90.6 or the lead agency's final decisions regarding public programs eligibility according to section
90.7 256.045, subdivision 3.

90.8 (i) Face-to-face assessment completed as part of eligibility determination for the
90.9 alternative care, elderly waiver, community access for disability inclusion, community
90.10 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,
90.11 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after
90.12 the date of assessment.

90.13 (j) The effective eligibility start date for programs in paragraph (i) can never be prior to
90.14 the date of assessment. If an assessment was completed more than 60 days before the
90.15 effective waiver or alternative care program eligibility start date, assessment and support
90.16 plan information must be updated and documented in the department's Medicaid Management
90.17 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
90.18 state plan services, the effective date of eligibility for programs included in paragraph (i)
90.19 cannot be prior to the date the most recent updated assessment is completed.

90.20 (k) At the time of reassessment, the certified assessor shall assess each person receiving
90.21 waiver services currently residing in a community residential setting, or licensed adult foster
90.22 care home that is not the primary residence of the license holder, or in which the license
90.23 holder is not the primary caregiver, to determine if that person would prefer to be served in
90.24 a community-living settings as defined in section 256B.49, subdivision 23. The certified
90.25 assessor shall offer the person, through a person-centered planning process, the option to
90.26 receive alternative housing and service options.

90.27 Sec. 15. Minnesota Statutes 2016, section 256B.0915, subdivision 1, is amended to read:

90.28 Subdivision 1. **Authority.** (a) The commissioner is authorized to apply for a home and
90.29 community-based services waiver for the elderly, authorized under section 1915(c) of the
90.30 Social Security Act, in order to obtain federal financial participation to expand the availability
90.31 of services for persons who are eligible for medical assistance. The commissioner may
90.32 apply for additional waivers or pursue other federal financial participation which is
90.33 advantageous to the state for funding home care services for the frail elderly who are eligible
90.34 for medical assistance. The provision of waived services to elderly and disabled medical

91.1 assistance recipients must comply with the criteria for service definitions and provider
91.2 standards approved in the waiver.

91.3 (b) The commissioner shall comply with the requirements in the federally approved
91.4 transition plan for the home and community-based services waivers authorized under this
91.5 section.

91.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

91.7 Sec. 16. Minnesota Statutes 2016, section 256B.092, subdivision 4, is amended to read:

91.8 Subd. 4. **Home and community-based services for developmental disabilities.** (a)
91.9 The commissioner shall make payments to approved vendors participating in the medical
91.10 assistance program to pay costs of providing home and community-based services, including
91.11 case management service activities provided as an approved home and community-based
91.12 service, to medical assistance eligible persons with developmental disabilities who have
91.13 been screened under subdivision 7 and according to federal requirements. Federal
91.14 requirements include those services and limitations included in the federally approved
91.15 application for home and community-based services for persons with developmental
91.16 disabilities and subsequent amendments.

91.17 (b) Effective July 1, 1995, contingent upon federal approval and state appropriations
91.18 made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8,
91.19 section 40, the commissioner of human services shall allocate resources to county agencies
91.20 for home and community-based waived services for persons with developmental disabilities
91.21 authorized but not receiving those services as of June 30, 1995, based upon the average
91.22 resource need of persons with similar functional characteristics. To ensure service continuity
91.23 for service recipients receiving home and community-based waived services for persons
91.24 with developmental disabilities prior to July 1, 1995, the commissioner shall make available
91.25 to the county of financial responsibility home and community-based waived services
91.26 resources based upon fiscal year 1995 authorized levels.

91.27 (c) Home and community-based resources for all recipients shall be managed by the
91.28 county of financial responsibility within an allowable reimbursement average established
91.29 for each county. Payments for home and community-based services provided to individual
91.30 recipients shall not exceed amounts authorized by the county of financial responsibility.
91.31 For specifically identified former residents of nursing facilities, the commissioner shall be
91.32 responsible for authorizing payments and payment limits under the appropriate home and
91.33 community-based service program. Payment is available under this subdivision only for

92.1 persons who, if not provided these services, would require the level of care provided in an
 92.2 intermediate care facility for persons with developmental disabilities.

92.3 (d) The commissioner shall comply with the requirements in the federally approved
 92.4 transition plan for the home and community-based services waivers for the elderly authorized
 92.5 under this section.

92.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

92.7 Sec. 17. Minnesota Statutes 2016, section 256B.49, subdivision 11, is amended to read:

92.8 Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and
 92.9 community-based service waivers, as authorized under section 1915(c) of the Social Security
 92.10 Act to serve persons under the age of 65 who are determined to require the level of care
 92.11 provided in a nursing home and persons who require the level of care provided in a hospital.
 92.12 The commissioner shall apply for the home and community-based waivers in order to:

- 92.13 (1) promote the support of persons with disabilities in the most integrated settings;
 92.14 (2) expand the availability of services for persons who are eligible for medical assistance;
 92.15 (3) promote cost-effective options to institutional care; and
 92.16 (4) obtain federal financial participation.

92.17 (b) The provision of waived services to medical assistance recipients with disabilities
 92.18 shall comply with the requirements outlined in the federally approved applications for home
 92.19 and community-based services and subsequent amendments, including provision of services
 92.20 according to a service plan designed to meet the needs of the individual. For purposes of
 92.21 this section, the approved home and community-based application is considered the necessary
 92.22 federal requirement.

92.23 (c) The commissioner shall provide interested persons serving on agency advisory
 92.24 committees, task forces, the Centers for Independent Living, and others who request to be
 92.25 on a list to receive, notice of, and an opportunity to comment on, at least 30 days before
 92.26 any effective dates, (1) any substantive changes to the state's disability services program
 92.27 manual, or (2) changes or amendments to the federally approved applications for home and
 92.28 community-based waivers, prior to their submission to the federal Centers for Medicare
 92.29 and Medicaid Services.

92.30 (d) The commissioner shall seek approval, as authorized under section 1915(c) of the
 92.31 Social Security Act, to allow medical assistance eligibility under this section for children
 92.32 under age 21 without deeming of parental income or assets.

93.1 (e) The commissioner shall seek approval, as authorized under section 1915(c) of the
 93.2 Social Act, to allow medical assistance eligibility under this section for individuals under
 93.3 age 65 without deeming the spouse's income or assets.

93.4 (f) The commissioner shall comply with the requirements in the federally approved
 93.5 transition plan for the home and community-based services waivers authorized under this
 93.6 section.

93.7 **EFFECTIVE DATE.** This section is effective the day following final enactment.

93.8 Sec. 18. Minnesota Statutes 2016, section 256B.49, subdivision 15, is amended to read:

93.9 Subd. 15. **Coordinated service and support plan; comprehensive transitional service**
 93.10 **plan; maintenance service plan.** (a) Each recipient of home and community-based waived
 93.11 services shall be provided a copy of the written coordinated service and support plan which
 93.12 meets the requirements in section 256B.092, subdivision 1b.

93.13 (b) In developing the comprehensive transitional service plan, the individual receiving
 93.14 services, the case manager, and the guardian, if applicable, will identify the transitional
 93.15 service plan fundamental service outcome and anticipated timeline to achieve this outcome.
 93.16 Within the first 20 days following a recipient's request for an assessment or reassessment,
 93.17 the transitional service planning team must be identified. A team leader must be identified
 93.18 who will be responsible for assigning responsibility and communicating with team members
 93.19 to ensure implementation of the transition plan and ongoing assessment and communication
 93.20 process. The team leader should be an individual, such as the case manager or guardian,
 93.21 who has the opportunity to follow the recipient to the next level of service.

93.22 Within ten days following an assessment, a comprehensive transitional service plan must
 93.23 be developed incorporating elements of a comprehensive functional assessment and including
 93.24 short-term measurable outcomes and timelines for achievement of and reporting on these
 93.25 outcomes. Functional milestones must also be identified and reported according to the
 93.26 timelines agreed upon by the transitional service planning team. In addition, the
 93.27 comprehensive transitional service plan must identify additional supports that may assist
 93.28 in the achievement of the fundamental service outcome such as the development of greater
 93.29 natural community support, increased collaboration among agencies, and technological
 93.30 supports.

93.31 The timelines for reporting on functional milestones will prompt a reassessment of
 93.32 services provided, the units of services, rates, and appropriate service providers. It is the
 93.33 responsibility of the transitional service planning team leader to review functional milestone

94.1 reporting to determine if the milestones are consistent with observable skills and that
94.2 milestone achievement prompts any needed changes to the comprehensive transitional
94.3 service plan.

94.4 For those whose fundamental transitional service outcome involves the need to procure
94.5 housing, a plan for the recipient to seek the resources necessary to secure the least restrictive
94.6 housing possible should be incorporated into the plan, including employment and public
94.7 supports such as housing access and shelter needy funding.

94.8 (c) Counties and other agencies responsible for funding community placement and
94.9 ongoing community supportive services are responsible for the implementation of the
94.10 comprehensive transitional service plans. Oversight responsibilities include both ensuring
94.11 effective transitional service delivery and efficient utilization of funding resources.

94.12 (d) Following one year of transitional services, the transitional services planning team
94.13 will make a determination as to whether or not the individual receiving services requires
94.14 the current level of continuous and consistent support in order to maintain the recipient's
94.15 current level of functioning. Recipients who are determined to have not had a significant
94.16 change in functioning for 12 months must move from a transitional to a maintenance service
94.17 plan. Recipients on a maintenance service plan must be reassessed to determine if the
94.18 recipient would benefit from a transitional service plan at least every 12 months and at other
94.19 times when there has been a significant change in the recipient's functioning. This assessment
94.20 should consider any changes to technological or natural community supports.

94.21 (e) When a county is evaluating denials, reductions, or terminations of home and
94.22 community-based services under this section for an individual, the case manager shall offer
94.23 to meet with the individual or the individual's guardian in order to discuss the prioritization
94.24 of service needs within the coordinated service and support plan, comprehensive transitional
94.25 service plan, or maintenance service plan. The reduction in the authorized services for an
94.26 individual due to changes in funding for waived services may not exceed the amount
94.27 needed to ensure medically necessary services to meet the individual's health, safety, and
94.28 welfare.

94.29 ~~(f) At the time of reassessment, local agency case managers shall assess each recipient~~
94.30 ~~of community access for disability inclusion or brain injury waived services currently~~
94.31 ~~residing in a licensed adult foster home that is not the primary residence of the license~~
94.32 ~~holder, or in which the license holder is not the primary caregiver, to determine if that~~
94.33 ~~recipient could appropriately be served in a community living setting. If appropriate for the~~
94.34 ~~recipient, the case manager shall offer the recipient, through a person-centered planning~~

95.1 ~~process, the option to receive alternative housing and service options. In the event that the~~
 95.2 ~~recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled~~
 95.3 ~~with another recipient of waiver services and group residential housing and the licensed~~
 95.4 ~~capacity shall be reduced accordingly, unless the savings required by the licensed bed closure~~
 95.5 ~~reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40,~~
 95.6 ~~paragraph (f), for foster care settings where the physical location is not the primary residence~~
 95.7 ~~of the license holder are met through voluntary changes described in section 245A.03,~~
 95.8 ~~subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the~~
 95.9 ~~adult foster home becomes no longer viable due to these transfers, the county agency, with~~
 95.10 ~~the assistance of the department, shall facilitate a consolidation of settings or closure. This~~
 95.11 ~~reassessment process shall be completed by July 1, 2013.~~

95.12 Sec. 19. Minnesota Statutes 2016, section 256B.493, subdivision 1, is amended to read:

95.13 Subdivision 1. **Commissioner's duties; report.** The commissioner of human services
 95.14 ~~shall solicit proposals for the conversion of services provided for persons with disabilities~~
 95.15 ~~in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, or community~~
 95.16 ~~residential settings licensed under chapter 245D, to other types of community settings in~~
 95.17 ~~conjunction with the closure of identified licensed adult foster care settings~~ has the authority
 95.18 to manage statewide licensed corporate foster care or community residential settings capacity,
 95.19 including the reduction and realignment of licensed capacity of a current foster care or
 95.20 community residential settings to accomplish the consolidation or closure of settings. The
 95.21 commissioner shall implement a program for planned closure of licensed corporate adult
 95.22 foster care or community residential settings, necessary as a preferred method to: (1) respond
 95.23 to the informed decisions of those individuals who want to move out of these settings into
 95.24 other types of community settings; and (2) achieve necessary budgetary savings required
 95.25 in section 245A.03, subdivision 7, paragraphs (c) and (d).

95.26 Sec. 20. Minnesota Statutes 2016, section 256B.493, subdivision 2, is amended to read:

95.27 Subd. 2. **Planned closure process needs determination.** ~~The commissioner shall~~
 95.28 ~~announce and implement a program for planned closure of adult foster care homes. Planned~~
 95.29 ~~closure shall be the preferred method for achieving necessary budgetary savings required~~
 95.30 ~~by the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph~~
 95.31 ~~(e). If additional closures are required to achieve the necessary savings, the commissioner~~
 95.32 ~~shall use the process and priorities in section 245A.03, subdivision 7, paragraph (e) A~~
 95.33 resource need determination process, managed at the state level, using available reports

96.1 required by section 144A.351 and other data and information shall be used by the
96.2 commissioner to align capacity where needed.

96.3 Sec. 21. Minnesota Statutes 2016, section 256B.493, is amended by adding a subdivision
96.4 to read:

96.5 Subd. 2a. **Closure process.** (a) The commissioner shall work with stakeholders to
96.6 establish a process for the application, review, approval, and implementation of setting
96.7 closures. Voluntary proposals from license holders for consolidation and closure of adult
96.8 foster care or community residential settings are encouraged. Whether voluntary or
96.9 involuntary, all closure plans must include:

96.10 (1) a description of the proposed closure plan, identifying the home or homes and
96.11 occupied beds;

96.12 (2) the proposed timetable for the proposed closure, including the proposed dates for
96.13 notification to people living there and the affected lead agencies, commencement of closure,
96.14 and completion of closure;

96.15 (3) the proposed relocation plan jointly developed by the counties of financial
96.16 responsibility, the people living there and their legal representatives, if any, who wish to
96.17 continue to receive services from the provider, and the providers for current residents of
96.18 any adult foster care home designated for closure; and

96.19 (4) documentation from the provider in a format approved by the commissioner that all
96.20 the adult foster care homes or community residential settings receiving a planned closure
96.21 rate adjustment under the plan have accepted joint and severable for recovery of
96.22 overpayments under section 256B.0641, subdivision 2, for the facilities designated for
96.23 closure under this plan.

96.24 (b) The commissioner shall give first priority to closure plans which:

96.25 (1) target counties and geographic areas which have:

96.26 (i) need for other types of services;

96.27 (ii) need for specialized services;

96.28 (iii) higher than average per capita use of licensed corporate foster care or community
96.29 residential settings; or

96.30 (iv) residents not living in the geographic area of their choice;

96.31 (2) demonstrate savings of medical assistance expenditures; and

97.1 (3) demonstrate that alternative services are based on the recipient's choice of provider
 97.2 and are consistent with federal law, state law, and federally approved waiver plans.

97.3 The commissioner shall also consider any information provided by people using services,
 97.4 their legal representatives, family members, or the lead agency on the impact of the planned
 97.5 closure on people and the services they need.

97.6 (c) For each closure plan approved by the commissioner, a contract must be established
 97.7 between the commissioner, the counties of financial responsibility, and the participating
 97.8 license holder.

97.9 Sec. 22. Minnesota Statutes 2016, section 256D.44, subdivision 4, is amended to read:

97.10 Subd. 4. **Temporary absence due to illness.** For the purposes of this subdivision, "home"
 97.11 means a residence owned or rented by a recipient or the recipient's spouse. ~~Home does not~~
 97.12 ~~include a group residential housing facility.~~ Assistance payments for recipients who are
 97.13 temporarily absent from their home due to hospitalization for illness must continue at the
 97.14 same level of payment during their absence if the following criteria are met:

97.15 (1) a physician certifies that the absence is not expected to continue for more than three
 97.16 months;

97.17 (2) a physician certifies that the recipient will be able to return to independent living;
 97.18 and

97.19 (3) the recipient has expenses associated with maintaining a residence in the community.

97.20 Sec. 23. Minnesota Statutes 2016, section 256D.44, subdivision 5, is amended to read:

97.21 Subd. 5. **Special needs.** (a) In addition to the state standards of assistance established
 97.22 in subdivisions 1 to 4, payments are allowed for the following special needs of recipients
 97.23 of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
 97.24 center, or a ~~group residential~~ setting authorized to receive housing facility support payments
 97.25 under chapter 256I.

97.26 ~~(a)~~ (b) The county agency shall pay a monthly allowance for medically prescribed diets
 97.27 if the cost of those additional dietary needs cannot be met through some other maintenance
 97.28 benefit. The need for special diets or dietary items must be prescribed by a licensed physician.
 97.29 Costs for special diets shall be determined as percentages of the allotment for a one-person
 97.30 household under the thrifty food plan as defined by the United States Department of
 97.31 Agriculture. The types of diets and the percentages of the thrifty food plan that are covered
 97.32 are as follows:

- 98.1 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;
- 98.2 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of
98.3 thrifty food plan;
- 98.4 (3) controlled protein diet, less than 40 grams and requires special products, 125 percent
98.5 of thrifty food plan;
- 98.6 (4) low cholesterol diet, 25 percent of thrifty food plan;
- 98.7 (5) high residue diet, 20 percent of thrifty food plan;
- 98.8 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;
- 98.9 (7) gluten-free diet, 25 percent of thrifty food plan;
- 98.10 (8) lactose-free diet, 25 percent of thrifty food plan;
- 98.11 (9) antidumping diet, 15 percent of thrifty food plan;
- 98.12 (10) hypoglycemic diet, 15 percent of thrifty food plan; or
- 98.13 (11) ketogenic diet, 25 percent of thrifty food plan.
- 98.14 ~~(b)~~ (c) Payment for nonrecurring special needs must be allowed for necessary home
98.15 repairs or necessary repairs or replacement of household furniture and appliances using the
98.16 payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as
98.17 long as other funding sources are not available.
- 98.18 ~~(e)~~ (d) A fee for guardian or conservator service is allowed at a reasonable rate negotiated
98.19 by the county or approved by the court. This rate shall not exceed five percent of the
98.20 assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian
98.21 or conservator is a member of the county agency staff, no fee is allowed.
- 98.22 ~~(d)~~ (e) The county agency shall continue to pay a monthly allowance of \$68 for restaurant
98.23 meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and
98.24 who eats two or more meals in a restaurant daily. The allowance must continue until the
98.25 person has not received Minnesota supplemental aid for one full calendar month or until
98.26 the person's living arrangement changes and the person no longer meets the criteria for the
98.27 restaurant meal allowance, whichever occurs first.
- 98.28 ~~(e)~~ (f) A fee of ten percent of the recipient's gross income or \$25, whichever is less, is
98.29 allowed for representative payee services provided by an agency that meets the requirements
98.30 under SSI regulations to charge a fee for representative payee services. This special need

99.1 is available to all recipients of Minnesota supplemental aid regardless of their living
99.2 arrangement.

99.3 ~~(f)~~ (g)(1) Notwithstanding the language in this subdivision, an amount equal to one-half
99.4 of the maximum allotment authorized by the federal Food Stamp Program for a federal
99.5 Supplemental Security Income payment amount for a single individual which is in effect
99.6 on the first day of July of each year will be added to the standards of assistance established
99.7 in subdivisions 1 to 4 for adults under the age of 65 who qualify as ~~shelter needy~~ in need
99.8 of housing assistance and are:

99.9 (i) relocating from an institution, a setting authorized to receive housing support under
99.10 chapter 256I, or an adult mental health residential treatment program under section
99.11 256B.0622; ~~or~~

99.12 (ii) eligible for personal care assistance under section 256B.0659; or

99.13 (iii) home and community-based waiver recipients living in their own home or rented
99.14 or leased apartment which is not owned, operated, or controlled by a provider of service
99.15 not related by blood or marriage, unless allowed under paragraph (g).

99.16 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter
99.17 needy benefit under this paragraph is considered a household of one. An eligible individual
99.18 who receives this benefit prior to age 65 may continue to receive the benefit after the age
99.19 of 65.

99.20 (3) "~~Shelter-needy~~ Housing assistance" means that the assistance unit incurs monthly
99.21 shelter costs that exceed 40 percent of the assistance unit's gross income before the application
99.22 of this special needs standard. "Gross income" for the purposes of this section is the
99.23 applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the
99.24 standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient
99.25 of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income,
99.26 shall not be considered ~~shelter-needy~~ in need of housing assistance for purposes of this
99.27 paragraph.

99.28 ~~(g)~~ Notwithstanding this subdivision, ~~to access housing and services as provided in~~
99.29 ~~paragraph (f), the recipient may choose housing that may be owned, operated, or controlled~~
99.30 ~~by the recipient's service provider. When housing is controlled by the service provider, the~~
99.31 ~~individual may choose the individual's own service provider as provided in section 256B.49,~~
99.32 ~~subdivision 23, clause (3). When the housing is controlled by the service provider, the~~
99.33 ~~service provider shall implement a plan with the recipient to transition the lease to the~~
99.34 ~~recipient's name. Within two years of signing the initial lease, the service provider shall~~

100.1 ~~transfer the lease entered into under this subdivision to the recipient. In the event the landlord~~
 100.2 ~~denies this transfer, the commissioner may approve an exception within sufficient time to~~
 100.3 ~~ensure the continued occupancy by the recipient. This paragraph expires June 30, 2016.~~

100.4 **EFFECTIVE DATE.** Paragraphs (a) to (f) are effective July 1, 2017. Paragraph (g),
 100.5 clause (1), is effective July 1, 2020, except paragraph (g), clause (1), items (ii) and (iii), are
 100.6 effective July 1, 2017.

100.7 Sec. 24. Minnesota Statutes 2016, section 256I.03, subdivision 8, is amended to read:

100.8 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
 100.9 services provided to ~~residents of group residential housing providers~~ individuals in addition
 100.10 to room and board including, but not limited to, oversight and up to 24-hour supervision,
 100.11 medication reminders, assistance with transportation, arranging for meetings and
 100.12 appointments, and arranging for medical and social services.

100.13 Sec. 25. Minnesota Statutes 2016, section 256I.04, subdivision 1, is amended to read:

100.14 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and
 100.15 entitled to a ~~group residential housing support~~ housing support payment to be made on the individual's behalf
 100.16 if the agency has approved the ~~individual's residence in a group residential setting where~~
 100.17 the individual will receive housing setting support and the individual meets the requirements
 100.18 in paragraph (a) ~~or~~, (b), or (c).

100.19 (a) The individual is aged, blind, or is over 18 years of age and disabled as determined
 100.20 under the criteria used by the title II program of the Social Security Act, and meets the
 100.21 resource restrictions and standards of section 256P.02, and the individual's countable income
 100.22 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical
 100.23 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the
 100.24 income actually made available to a community spouse by an elderly waiver participant
 100.25 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,
 100.26 subdivision 2, is less than the monthly rate specified in the agency's agreement with the
 100.27 provider of ~~group residential housing support~~ housing support in which the individual resides.

100.28 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
 100.29 paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and the
 100.30 individual's resources are less than the standards specified by section 256P.02, and the
 100.31 individual's countable income as determined under section 256P.06, less the medical
 100.32 assistance personal needs allowance under section 256B.35 is less than the monthly rate

101.1 specified in the agency's agreement with the provider of ~~group residential~~ housing support
101.2 in which the individual resides.

101.3 (c) The individual receives licensed residential crisis stabilization services under section
101.4 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive
101.5 concurrent housing support payments if receiving licensed residential crisis stabilization
101.6 services under section 256B.0624, subdivision 7.

101.7 **EFFECTIVE DATE.** Paragraph (c) is effective October 1, 2017.

101.8 Sec. 26. Minnesota Statutes 2016, section 256I.04, subdivision 2d, is amended to read:

101.9 Subd. 2d. **Conditions of payment; commissioner's right to suspend or terminate**
101.10 **agreement.** (a) ~~Group residential~~ Housing or ~~supplementary services~~ support must be
101.11 provided to the satisfaction of the commissioner, as determined at the sole discretion of the
101.12 commissioner's authorized representative, and in accordance with all applicable federal,
101.13 state, and local laws, ordinances, rules, and regulations, including business registration
101.14 requirements of the Office of the Secretary of State. A provider shall not receive payment
101.15 for room and board or supplementary services or ~~housing~~ found by the commissioner to be
101.16 performed or provided in violation of federal, state, or local law, ordinance, rule, or
101.17 regulation.

101.18 (b) The commissioner has the right to suspend or terminate the agreement immediately
101.19 when the commissioner determines the health or welfare of the housing or service recipients
101.20 is endangered, or when the commissioner has reasonable cause to believe that the provider
101.21 has breached a material term of the agreement under subdivision 2b.

101.22 (c) Notwithstanding paragraph (b), if the commissioner learns of a curable material
101.23 breach of the agreement by the provider, the commissioner shall provide the provider with
101.24 a written notice of the breach and allow ten days to cure the breach. If the provider does
101.25 not cure the breach within the time allowed, the provider shall be in default of the agreement
101.26 and the commissioner may terminate the agreement immediately thereafter. If the provider
101.27 has breached a material term of the agreement and cure is not possible, the commissioner
101.28 may immediately terminate the agreement.

101.29 Sec. 27. Minnesota Statutes 2016, section 256I.04, subdivision 2g, is amended to read:

101.30 Subd. 2g. **Crisis shelters.** Secure crisis shelters for battered women and their children
101.31 designated by the Minnesota Department of Corrections are not ~~group residences~~ eligible
101.32 for housing support under this chapter.

102.1 Sec. 28. Minnesota Statutes 2016, section 256I.04, subdivision 3, is amended to read:

102.2 Subd. 3. **Moratorium on development of ~~group residential housing support~~ beds.**

102.3 (a) Agencies shall not enter into agreements for new ~~group residential housing support~~ beds
102.4 with total rates in excess of the MSA equivalent rate except:

102.5 (1) for ~~group residential housing~~ establishments licensed under chapter 245D provided
102.6 the facility is needed to meet the census reduction targets for persons with developmental
102.7 disabilities at regional treatment centers;

102.8 (2) up to 80 beds in a single, specialized facility located in Hennepin County that will
102.9 provide housing for chronic inebriates who are repetitive users of detoxification centers and
102.10 are refused placement in emergency shelters because of their state of intoxication, and
102.11 planning for the specialized facility must have been initiated before July 1, 1991, in
102.12 anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,
102.13 subdivision 20a, paragraph (b);

102.14 (3) notwithstanding the provisions of subdivision 2a, for up to ~~190~~ 226 supportive
102.15 housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a
102.16 mental illness, a history of substance abuse, or human immunodeficiency virus or acquired
102.17 immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person
102.18 who is living on the street or in a shelter or discharged from a regional treatment center,
102.19 community hospital, or residential treatment program and has no appropriate housing
102.20 available and lacks the resources and support necessary to access appropriate housing. At
102.21 least 70 percent of the supportive housing units must serve homeless adults with mental
102.22 illness, substance abuse problems, or human immunodeficiency virus or acquired
102.23 immunodeficiency syndrome who are about to be or, within the previous six months, has
102.24 been discharged from a regional treatment center, or a state-contracted psychiatric bed in
102.25 a community hospital, or a residential mental health or chemical dependency treatment
102.26 program. If a person meets the requirements of subdivision 1, paragraph (a), and receives
102.27 a federal or state housing subsidy, the ~~group residential housing support~~ rate for that person
102.28 is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined
102.29 by subtracting the amount of the person's countable income that exceeds the MSA equivalent
102.30 rate from the ~~group residential housing support~~ supplementary service rate. A resident in a
102.31 demonstration project site who no longer participates in the demonstration program shall
102.32 retain eligibility for a ~~group residential housing support~~ payment in an amount determined
102.33 under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under
102.34 section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are
102.35 available and the services can be provided through a managed care entity. If federal matching

103.1 funds are not available, then service funding will continue under section 256I.05, subdivision
103.2 1a;

103.3 (4) for an additional two beds, resulting in a total of 32 beds, for a facility located in
103.4 Hennepin County providing services for recovering and chemically dependent men that has
103.5 had a ~~group residential~~ housing support contract with the county and has been licensed as
103.6 a board and lodge facility with special services since 1980;

103.7 (5) for a ~~group residential~~ housing support provider located in the city of St. Cloud, or
103.8 a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received
103.9 financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness
103.10 Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

103.11 (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent
103.12 persons, operated by a ~~group residential~~ housing support provider that currently operates a
103.13 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

103.14 (7) for a ~~group residential~~ housing support provider that operates two ten-bed facilities,
103.15 one located in Hennepin County and one located in Ramsey County, that provide community
103.16 support and 24-hour-a-day supervision to serve the mental health needs of individuals who
103.17 have chronically lived unsheltered; and

103.18 (8) for a ~~group residential~~ facility authorized for recipients of housing support in Hennepin
103.19 County with a capacity of up to 48 beds that has been licensed since 1978 as a board and
103.20 lodging facility and that until August 1, 2007, operated as a licensed chemical dependency
103.21 treatment program.

103.22 (b) An agency may enter into a ~~group residential~~ housing support agreement for beds
103.23 with rates in excess of the MSA equivalent rate in addition to those currently covered under
103.24 a ~~group residential~~ housing support agreement if the additional beds are only a replacement
103.25 of beds with rates in excess of the MSA equivalent rate which have been made available
103.26 due to closure of a setting, a change of licensure or certification which removes the beds
103.27 from ~~group residential~~ housing support payment, or as a result of the downsizing of a ~~group~~
103.28 ~~residential housing~~ setting authorized for recipients of housing support. The transfer of
103.29 available beds from one agency to another can only occur by the agreement of both agencies.

103.30 Sec. 29. Minnesota Statutes 2016, section 256I.05, subdivision 1a, is amended to read:

103.31 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,
103.32 subdivision 3, the county agency may negotiate a payment not to exceed \$426.37 for other
103.33 services necessary to provide room and board ~~provided by the group residence~~ if the residence

104.1 is licensed by or registered by the Department of Health, or licensed by the Department of
104.2 Human Services to provide services in addition to room and board, and if the provider of
104.3 services is not also concurrently receiving funding for services for a recipient under a home
104.4 and community-based waiver under title XIX of the Social Security Act; or funding from
104.5 the medical assistance program under section 256B.0659, for personal care services for
104.6 residents in the setting; or residing in a setting which receives funding under section 245.73.
104.7 If funding is available for other necessary services through a home and community-based
104.8 waiver, or personal care services under section 256B.0659, then the ~~GRH~~ housing support
104.9 rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case
104.10 may the supplementary service rate exceed \$426.37. The registration and licensure
104.11 requirement does not apply to establishments which are exempt from state licensure because
104.12 they are located on Indian reservations and for which the tribe has prescribed health and
104.13 safety requirements. Service payments under this section may be prohibited under rules to
104.14 prevent the supplanting of federal funds with state funds. The commissioner shall pursue
104.15 the feasibility of obtaining the approval of the Secretary of Health and Human Services to
104.16 provide home and community-based waiver services under title XIX of the Social Security
104.17 Act for residents who are not eligible for an existing home and community-based waiver
104.18 due to a primary diagnosis of mental illness or chemical dependency and shall apply for a
104.19 waiver if it is determined to be cost-effective.

104.20 (b) The commissioner is authorized to make cost-neutral transfers from the ~~GRH~~ housing
104.21 support fund for beds under this section to other funding programs administered by the
104.22 department after consultation with the county or counties in which the affected beds are
104.23 located. The commissioner may also make cost-neutral transfers from the ~~GRH~~ housing
104.24 support fund to county human service agencies for beds permanently removed from the
104.25 ~~GRH~~ housing support census under a plan submitted by the county agency and approved
104.26 by the commissioner. The commissioner shall report the amount of any transfers under this
104.27 provision annually to the legislature.

104.28 (c) Counties must not negotiate supplementary service rates with providers of ~~group~~
104.29 ~~residential~~ housing support that are licensed as board and lodging with special services and
104.30 that do not encourage a policy of sobriety on their premises and make referrals to available
104.31 community services for volunteer and employment opportunities for residents.

105.1 Sec. 30. Minnesota Statutes 2016, section 256I.05, subdivision 1c, is amended to read:

105.2 Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for ~~group~~
105.3 ~~residential~~ housing support above those in effect on June 30, 1993, except as provided in
105.4 paragraphs (a) to (f).

105.5 (a) An agency may increase the rates for ~~group residential housing settings~~ room and
105.6 board to the MSA equivalent rate for those settings whose current rate is below the MSA
105.7 equivalent rate.

105.8 (b) An agency may increase the rates for residents in adult foster care whose difficulty
105.9 of care has increased. The total ~~group residential~~ housing support rate for these residents
105.10 must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not
105.11 include nor increase ~~group residential housing~~ difficulty of care rates for adults in foster
105.12 care whose difficulty of care is eligible for funding by home and community-based waiver
105.13 programs under title XIX of the Social Security Act.

105.14 (c) The room and board rates will be increased each year when the MSA equivalent rate
105.15 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less
105.16 the amount of the increase in the medical assistance personal needs allowance under section
105.17 256B.35.

105.18 (d) When a ~~group residential~~ housing ~~rate is used to pay~~ support pays for an individual's
105.19 room and board, or other costs necessary to provide room and board, the rate payable to the
105.20 residence must continue for up to 18 calendar days per incident that the person is temporarily
105.21 absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences
105.22 have received the prior approval of the county agency's social service staff. Prior approval
105.23 is not required for emergency absences due to crisis, illness, or injury.

105.24 (e) For facilities meeting substantial change criteria within the prior year. Substantial
105.25 change criteria exists if the ~~group residential housing~~ establishment experiences a 25 percent
105.26 increase or decrease in the total number of its beds, if the net cost of capital additions or
105.27 improvements is in excess of 15 percent of the current market value of the residence, or if
105.28 the residence physically moves, or changes its licensure, and incurs a resulting increase in
105.29 operation and property costs.

105.30 (f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid
105.31 for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who
105.32 reside in residences that are licensed by the commissioner of health as a boarding care home,
105.33 but are not certified for the purposes of the medical assistance program. However, an increase
105.34 under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical

106.1 assistance reimbursement rate for nursing home resident class A, in the geographic grouping
106.2 in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to
106.3 9549.0058.

106.4 Sec. 31. Minnesota Statutes 2016, section 256I.05, subdivision 1e, is amended to read:

106.5 Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the provisions
106.6 of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall negotiate a
106.7 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per
106.8 month, including any legislatively authorized inflationary adjustments, for a ~~group residential~~
106.9 housing support provider that:

106.10 (1) is located in Hennepin County and has had a ~~group residential~~ housing support
106.11 contract with the county since June 1996;

106.12 (2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a 26-bed
106.13 facility; and

106.14 (3) serves a chemically dependent clientele, providing 24 hours per day supervision and
106.15 limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month
106.16 period.

106.17 (b) Notwithstanding subdivisions 1a and 1c, a county agency shall negotiate a
106.18 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per
106.19 month, including any legislatively authorized inflationary adjustments, of a ~~group residential~~
106.20 housing support provider that:

106.21 (1) is located in St. Louis County and has had a ~~group residential~~ housing support contract
106.22 with the county since 2006;

106.23 (2) operates a 62-bed facility; and

106.24 (3) serves a chemically dependent adult male clientele, providing 24 hours per day
106.25 supervision and limiting a resident's maximum length of stay to 13 months out of a
106.26 consecutive 24-month period.

106.27 (c) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency
106.28 shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not
106.29 to exceed \$700 per month, including any legislatively authorized inflationary adjustments,
106.30 for the ~~group residential~~ provider described under paragraphs (a) and (b), not to exceed an
106.31 additional 115 beds.

107.1 Sec. 32. Minnesota Statutes 2016, section 256I.05, subdivision 1j, is amended to read:

107.2 Subd. 1j. **Supplementary rate for certain facilities; Crow Wing County.**

107.3 Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a county
 107.4 agency shall negotiate a supplementary rate in addition to the rate specified in subdivision
 107.5 1, not to exceed \$700 per month, including any legislatively authorized inflationary
 107.6 adjustments, for a new 65-bed facility in Crow Wing County that will serve chemically
 107.7 dependent persons operated by a ~~group residential~~ housing support provider that currently
 107.8 operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in
 107.9 January of 2006.

107.10 Sec. 33. Minnesota Statutes 2016, section 256I.05, subdivision 1m, is amended to read:

107.11 Subd. 1m. **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.**

107.12 (a) Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency
 107.13 shall negotiate a supplemental service rate in addition to the rate specified in subdivision
 107.14 1, not to exceed \$700 per month or the existing monthly rate, whichever is higher, including
 107.15 any legislatively authorized inflationary adjustments, for a ~~group residential~~ housing support
 107.16 provider that operates two ten-bed facilities, one located in Hennepin County and one located
 107.17 in Ramsey County, which provide community support and serve the mental health needs
 107.18 of individuals who have chronically lived unsheltered, providing 24-hour-per-day supervision.

107.19 (b) An individual who has lived in one of the facilities under paragraph (a), who is being
 107.20 transitioned to independent living as part of the program plan continues to be eligible for
 107.21 ~~group residential housing room and board~~ and the supplemental service rate negotiated with
 107.22 the county under paragraph (a).

107.23 Sec. 34. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
 107.24 to read:

107.25 Subd. 1p. **Supplementary rate; St. Louis County.** Notwithstanding the provisions of
 107.26 subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a
 107.27 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per
 107.28 month, including any legislatively authorized inflationary adjustments, for a housing support
 107.29 provider that:

107.30 (1) is located in St. Louis County and has had a housing support contract with the county
 107.31 since July 2016;

107.32 (2) operates a 35-bed facility;

- 108.1 (3) serves women who are chemically dependent, mentally ill, or both;
108.2 (4) provides 24-hour per day supervision;
108.3 (5) provides on-site support with skilled professionals, including a licensed practical
108.4 nurse, registered nurses, peer specialists, and resident counselors; and
108.5 (6) provides independent living skills training and assistance with family reunification.

108.6 Sec. 35. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
108.7 to read:

108.8 Subd. 1q. **Supplemental rate; Olmsted County.** Notwithstanding the provisions of
108.9 subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a
108.10 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$750 per
108.11 month, including any legislatively authorized inflationary adjustments, for a housing support
108.12 provider located in Olmsted County that operates long-term residential facilities with a total
108.13 of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day
108.14 supervision and other support services.

108.15 Sec. 36. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
108.16 to read:

108.17 Subd. 1r. **Supplemental rate; Anoka County.** Notwithstanding the provisions in this
108.18 section, a county agency shall negotiate a supplemental rate for 42 beds in addition to the
108.19 rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision
108.20 1a, including any legislatively authorized inflationary adjustments, for a housing support
108.21 provider that is located in Anoka County and provides emergency housing on the former
108.22 Anoka Regional Treatment Center campus.

108.23 Sec. 37. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
108.24 to read:

108.25 Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a
108.26 cost-neutral transfer of funding from the housing support fund to county human service
108.27 agencies for emergency shelter beds removed from the housing support census under a
108.28 biennial plan submitted by the county and approved by the commissioner. The plan must
108.29 describe: (1) anticipated and actual outcomes for persons experiencing homelessness in
108.30 emergency shelters; (2) improved efficiencies in administration; (3) requirements for
108.31 individual eligibility; and (4) plans for quality assurance monitoring and quality assurance

109.1 outcomes. The commissioner shall review the county plan to monitor implementation and
109.2 outcomes at least biennially, and more frequently if the commissioner deems necessary.

109.3 (b) The funding under paragraph (a) may be used for the provision of room and board
109.4 or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must
109.5 meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated
109.6 annually, and the room and board portion of the allocation shall be adjusted according to
109.7 the percentage change in the housing support room and board rate. The room and board
109.8 portion of the allocation shall be determined at the time of transfer. The commissioner or
109.9 county may return beds to the housing support fund with 180 days' notice, including financial
109.10 reconciliation.

109.11 **EFFECTIVE DATE.** This section is effective July 1, 2017.

109.12 Sec. 38. Minnesota Statutes 2016, section 256I.06, subdivision 2, is amended to read:

109.13 Subd. 2. **Time of payment.** A county agency may make payments ~~to a group residence~~
109.14 in advance for an individual whose stay ~~in the group residence~~ is expected to last beyond
109.15 the calendar month for which the payment is made. ~~Group residential~~ Housing support
109.16 payments made by a county agency on behalf of an individual who is not expected to remain
109.17 in the group residence beyond the month for which payment is made must be made
109.18 subsequent to the individual's departure from the ~~group~~ residence.

109.19 **EFFECTIVE DATE.** This section is effective July 1, 2017.

109.20 Sec. 39. Minnesota Statutes 2016, section 256I.06, subdivision 8, is amended to read:

109.21 Subd. 8. **Amount of ~~group residential~~ housing support payment.** (a) The amount of
109.22 a ~~group residential housing~~ room and board payment to be made on behalf of an eligible
109.23 individual is determined by subtracting the individual's countable income under section
109.24 256I.04, subdivision 1, for a whole calendar month from the ~~group residential housing~~
109.25 ~~charge~~ room and board rate for that same month. The ~~group residential~~ housing charge
109.26 support payment is determined by multiplying the ~~group residential~~ housing support rate
109.27 times the period of time the individual was a resident or temporarily absent under section
109.28 256I.05, subdivision 1c, paragraph (d).

109.29 (b) For an individual with earned income under paragraph (a), prospective budgeting
109.30 must be used to determine the amount of the individual's payment for the following six-month
109.31 period. An increase in income shall not affect an individual's eligibility or payment amount

110.1 until the month following the reporting month. A decrease in income shall be effective the
110.2 first day of the month after the month in which the decrease is reported.

110.3 (c) For an individual who receives licensed residential crisis stabilization services under
110.4 section 256B.0624, subdivision 7, the amount of housing support payment is determined
110.5 by multiplying the housing support rate times the period of time the individual was a resident.

110.6 **EFFECTIVE DATE.** Paragraph (c) is effective October 1, 2017.

110.7 Sec. 40. **[256I.09] COMMUNITY LIVING INFRASTRUCTURE.**

110.8 The commissioner shall awards grants to agencies through an annual competitive process.
110.9 Grants awarded under this section may be used for: (1) outreach to locate and engage people
110.10 who are homeless or residing in segregated settings to screen for basic needs and assist with
110.11 referral to community living resources; (2) building capacity to provide technical assistance
110.12 and consultation on housing and related support service resources for persons with both
110.13 disabilities and low income; or (3) streamlining the administration and monitoring activities
110.14 related to housing support funds. Agencies may collaborate and submit a joint application
110.15 for funding under this section.

110.16 Sec. 41. **DIRECTION TO COMMISSIONER; HOUSING SUPPORT STUDY.**

110.17 Within available appropriations, the commissioner of human services shall study the
110.18 housing support supplementary service rates under Minnesota Statutes, section 256I.05,
110.19 and make recommendations on the supplementary service rate structure to the chairs and
110.20 ranking minority members of the legislative committees with jurisdiction over human
110.21 services policy and finance by January 15, 2018.

110.22 Sec. 42. **REVISOR'S INSTRUCTION.**

110.23 In each section of Minnesota Statutes referred to in column A, the revisor of statutes
110.24 shall change the phrase in column B to the phrase in column C. The revisor may make
110.25 technical and other necessary changes to sentence structure to preserve the meaning of the
110.26 text. The revisor shall make other changes in chapter titles; section, subdivision, part, and
110.27 subpart headnotes; and in other terminology necessary as a result of the enactment of this
110.28 section.

110.29	<u>Column A</u>	<u>Column B</u>	<u>Column C</u>
110.30	<u>144A.071, subdivision 4d</u>	<u>group residential housing</u>	<u>housing support under chapter</u>
110.31			<u>256I</u>
110.32	<u>201.061, subdivision 3</u>	<u>group residential housing</u>	<u>setting authorized to provide</u>
110.33			<u>housing support</u>

111.1	<u>244.052, subdivision 4c</u>	<u>group residential housing facility</u>	<u>licensed setting authorized to provide housing support under section 256I.04</u>
111.2			
111.3			
111.4	<u>245.466, subdivision 7</u>	<u>under group residential housing</u>	<u>by housing support under chapter 256I</u>
111.5			
111.6	<u>245.466, subdivision 7</u>	<u>from group residential housing</u>	<u>from housing support</u>
111.7	<u>245.4661, subdivision 6</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
111.8			
111.9	<u>245C.10, subdivision 11</u>	<u>group residential housing or supplementary services</u>	<u>housing support</u>
111.10			
111.11	<u>256.01, subdivision 18</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
111.12			
111.13	<u>256.017, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
111.14	<u>256.98, subdivision 8</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
111.15			
111.16	<u>256B.49, subdivision 15</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
111.17			
111.18	<u>256B.4914, subdivision 10</u>	<u>group residential housing rate 3 costs</u>	<u>housing support rate 3 costs under chapter 256I</u>
111.19			
111.20	<u>256B.501, subdivision 4b</u>	<u>group residential housing</u>	<u>housing support</u>
111.21	<u>256B.77, subdivision 12</u>	<u>residential services covered under the group residential housing program</u>	<u>housing support services under chapter 256I</u>
111.22			
111.23			
111.24	<u>256D.44, subdivision 2</u>	<u>group residential housing facility</u>	<u>setting authorized to provide housing support</u>
111.25			
111.26	<u>256G.01, subdivision 3</u>	<u>group residential housing</u>	<u>housing support under chapter 256I</u>
111.27			
111.28	<u>256I.01</u>	<u>Group Residential Housing</u>	<u>Housing Support</u>
111.29	<u>256I.02</u>	<u>Group Residential Housing</u>	<u>Housing Support</u>
111.30	<u>256I.03, subdivision 2</u>	<u>"Group residential housing"</u>	<u>"Room and board"</u>
111.31	<u>256I.03, subdivision 2</u>	<u>Group residential housing</u>	<u>The room and board</u>
111.32	<u>256I.03, subdivision 3</u>	<u>"Group residential housing"</u>	<u>"Housing support"</u>
111.33	<u>256I.03, subdivision 6</u>	<u>group residential housing</u>	<u>room and board</u>
111.34	<u>256I.03, subdivisions 7 and 9</u>	<u>group residential housing</u>	<u>housing support</u>
111.35	<u>256I.04, subdivisions 1a, 1b, 1c, and 2</u>	<u>group residential housing</u>	<u>housing support</u>
111.36			
111.37	<u>256I.04, subdivision 2a</u>	<u>provide group residential housing</u>	<u>provide housing support</u>
111.38			
111.39	<u>256I.04, subdivision 2a</u>	<u>of group residential housing or supplementary services</u>	<u>of housing support</u>
111.40			
111.41	<u>256I.04, subdivision 2a</u>	<u>complete group residential housing</u>	<u>complete housing support</u>
111.42			
111.43	<u>256I.04, subdivision 2b</u>	<u>group residential housing or supplementary services</u>	<u>housing support</u>
111.44			

112.1	<u>256I.04, subdivision 2b</u>	<u>provision of group residential</u>	<u>provision of housing support</u>
112.2		<u>housing</u>	
112.3	<u>256I.04, subdivision 2c</u>	<u>group residential housing or</u>	<u>housing support</u>
112.4		<u>supplementary services</u>	
112.5	<u>256I.04, subdivision 2e</u>	<u>group residential housing or</u>	<u>housing support</u>
112.6		<u>supplementary services</u>	
112.7	<u>256I.04, subdivision 4</u>	<u>group residential housing</u>	<u>room and board rate</u>
112.8		<u>payment for room and board</u>	
112.9	<u>256I.05, subdivision 1</u>	<u>living in group residential</u>	<u>receiving housing support</u>
112.10		<u>housing</u>	
112.11	<u>256I.05, subdivisions 1h, 1k,</u>	<u>group residential housing</u>	<u>housing support</u>
112.12	<u>1l, 7b, and 7c</u>		
112.13	<u>256I.05, subdivision 2</u>	<u>group residential housing</u>	<u>room and board</u>
112.14	<u>256I.05, subdivision 3</u>	<u>group residential housing</u>	<u>room and board</u>
112.15	<u>256I.05, subdivision 6</u>	<u>reside in group residential</u>	<u>receive housing support</u>
112.16		<u>housing</u>	
112.17	<u>256I.06, subdivisions 1, 3, 4,</u>	<u>group residential housing</u>	<u>housing support</u>
112.18	<u>and 6</u>		
112.19	<u>256I.06, subdivision 7</u>	<u>group residential housing</u>	<u>the housing support</u>
112.20	<u>256I.08</u>	<u>group residential housing</u>	<u>housing support</u>
112.21	<u>256P.03, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
112.22	<u>256P.05, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
112.23	<u>256P.07, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
112.24	<u>256P.08, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
112.25	<u>290A.03, subdivision 8</u>	<u>accepts group residential</u>	<u>accepts housing support</u>
112.26		<u>housing</u>	
112.27	<u>290A.03, subdivision 8</u>	<u>the group residential housing</u>	<u>the housing support program</u>
112.28		<u>program</u>	

ARTICLE 3

CONTINUING CARE

112.31 Section 1. Minnesota Statutes 2016, section 144.0724, subdivision 4, is amended to read:

112.32 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
 112.33 submit to the commissioner of health MDS assessments that conform with the assessment
 112.34 schedule defined by Code of Federal Regulations, title 42, section 483.20, and published
 112.35 by the United States Department of Health and Human Services, Centers for Medicare and
 112.36 Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version
 112.37 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services.
 112.38 The commissioner of health may substitute successor manuals or question and answer
 112.39 documents published by the United States Department of Health and Human Services,

113.1 Centers for Medicare and Medicaid Services, to replace or supplement the current version
113.2 of the manual or document.

113.3 (b) The assessments used to determine a case mix classification for reimbursement
113.4 include the following:

113.5 (1) a new admission assessment;

113.6 (2) an annual assessment which must have an assessment reference date (ARD) within
113.7 92 days of the previous assessment and the previous comprehensive assessment;

113.8 (3) a significant change in status assessment must be completed within 14 days of the
113.9 identification of a significant change, whether improvement or decline, and regardless of
113.10 the amount of time since the last significant change in status assessment;

113.11 (4) all quarterly assessments must have an assessment reference date (ARD) within 92
113.12 days of the ARD of the previous assessment;

113.13 (5) any significant correction to a prior comprehensive assessment, if the assessment
113.14 being corrected is the current one being used for RUG classification; and

113.15 (6) any significant correction to a prior quarterly assessment, if the assessment being
113.16 corrected is the current one being used for RUG classification.

113.17 (c) In addition to the assessments listed in paragraph (b), the assessments used to
113.18 determine nursing facility level of care include the following:

113.19 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
113.20 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
113.21 Aging; and

113.22 (2) a nursing facility level of care determination as provided for under section 256B.0911,
113.23 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed
113.24 under section 256B.0911, by a county, tribe, or managed care organization under contract
113.25 with the Department of Human Services.

113.26 Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 6, is amended to read:

113.27 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or
113.28 submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within
113.29 seven days of the time requirements listed in the Long-Term Care Facility Resident
113.30 Assessment Instrument User's Manual is subject to a reduced rate for that resident. The
113.31 reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the
113.32 day of admission for new admission assessments, on the ARD for significant change in

114.1 status assessments, or on the day that the assessment was due for all other assessments and
114.2 continues in effect until the first day of the month following the date of submission and
114.3 acceptance of the resident's assessment.

114.4 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
114.5 are equal to or greater than ~~1.0~~ 0.1 percent of the total operating costs on the facility's most
114.6 recent annual statistical and cost report, a facility may apply to the commissioner of human
114.7 services for a reduction in the total penalty amount. The commissioner of human services,
114.8 in consultation with the commissioner of health, may, at the sole discretion of the
114.9 commissioner of human services, limit the penalty for residents covered by medical assistance
114.10 to ~~15~~ ten days.

114.11 **EFFECTIVE DATE.** This section is effective the day following final enactment.

114.12 Sec. 3. Minnesota Statutes 2016, section 144.562, subdivision 2, is amended to read:

114.13 Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a
114.14 license condition for swing beds unless (1) it either has a licensed bed capacity of less than
114.15 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42,
114.16 section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that
114.17 were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed
114.18 capacity of less than 65 beds and the available nursing homes within 50 miles have had, in
114.19 the aggregate, an average occupancy rate of 96 percent or higher in the most recent two
114.20 years as documented on the statistical reports to the Department of Health; and (2) it is
114.21 located in a rural area as defined in the federal Medicare regulations, Code of Federal
114.22 Regulations, title 42, section 482.66.

114.23 (b) Except for those critical access hospitals established under section 144.1483, clause
114.24 (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section
114.25 1395i-4, that have an attached nursing home or that owned a nursing home located in the
114.26 same municipality as of May 1, 2005, eligible hospitals are allowed a total of 2,000 days
114.27 of swing bed use per year. Critical access hospitals that have an attached nursing home or
114.28 that owned a nursing home located in the same municipality as of May 1, 2005, are allowed
114.29 swing bed use as provided in federal law.

114.30 (c) Except for critical access hospitals that have an attached nursing home or that owned
114.31 a nursing home located in the same municipality as of May 1, 2005, the commissioner of
114.32 health may approve swing bed use beyond 2,000 days as long as there are no Medicare
114.33 certified skilled nursing facility beds available within 25 miles of that hospital that are
114.34 willing to admit the patient and the patient agrees to the referral being sent to the skilled

115.1 nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain
 115.2 documentation that they have contacted skilled nursing facilities within 25 miles to determine
 115.3 if any skilled nursing facility beds are available that are willing to admit the patient and the
 115.4 patient agrees to the referral being sent to the skilled nursing facility.

115.5 (d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which
 115.6 this limit applies may admit six additional patients to swing beds each year without seeking
 115.7 approval from the commissioner or being in violation of this subdivision. These six swing
 115.8 bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals
 115.9 subject to this limit.

115.10 (e) A health care system that is in full compliance with this subdivision may allocate its
 115.11 total limit of swing bed days among the hospitals within the system, provided that no hospital
 115.12 in the system without an attached nursing home may exceed 2,000 swing bed days per year.

115.13 Sec. 4. Minnesota Statutes 2016, section 144A.071, subdivision 4d, is amended to read:

115.14 Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in
 115.15 consultation with the commissioner of human services, may approve a request for
 115.16 consolidation of nursing facilities which includes the closure of one or more facilities and
 115.17 the upgrading of the physical plant of the remaining nursing facility or facilities, the costs
 115.18 of which exceed the threshold project limit under subdivision 2, clause (a). The
 115.19 commissioners shall consider the criteria in this section, section 144A.073, and section
 115.20 ~~256B.437~~ 256R.40, in approving or rejecting a consolidation proposal. In the event the
 115.21 commissioners approve the request, the commissioner of human services shall calculate an
 115.22 external fixed costs rate adjustment according to clauses (1) to (3):

115.23 (1) the closure of beds shall not be eligible for a planned closure rate adjustment under
 115.24 section ~~256B.437, subdivision 6~~ 256R.40, subdivision 5;

115.25 (2) the construction project permitted in this clause shall not be eligible for a threshold
 115.26 project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception
 115.27 adjustment under section 144A.073; and

115.28 (3) the payment rate for external fixed costs for a remaining facility or facilities shall
 115.29 be increased by an amount equal to 65 percent of the projected net cost savings to the state
 115.30 calculated in paragraph (b), divided by the state's medical assistance percentage of medical
 115.31 assistance dollars, and then divided by estimated medical assistance resident days, as
 115.32 determined in paragraph (c), of the remaining nursing facility or facilities in the request in
 115.33 this paragraph. The rate adjustment is effective on the ~~later of the first day of the month~~

116.1 ~~following~~ first day of the month of January or July, whichever date occurs first following
116.2 both the completion of the construction upgrades in the consolidation plan or the first day
116.3 ~~of the month following~~ and the complete closure of a facility closure of the facility or
116.4 facilities designated for closure in the consolidation plan. If more than one facility is receiving
116.5 upgrades in the consolidation plan, each facility's date of construction completion must be
116.6 evaluated separately.

116.7 (b) For purposes of calculating the net cost savings to the state, the commissioner shall
116.8 consider clauses (1) to (7):

116.9 (1) the annual savings from estimated medical assistance payments from the net number
116.10 of beds closed taking into consideration only beds that are in active service on the date of
116.11 the request and that have been in active service for at least three years;

116.12 (2) the estimated annual cost of increased case load of individuals receiving services
116.13 under the elderly waiver;

116.14 (3) the estimated annual cost of elderly waiver recipients receiving support under group
116.15 residential housing;

116.16 (4) the estimated annual cost of increased case load of individuals receiving services
116.17 under the alternative care program;

116.18 (5) the annual loss of license surcharge payments on closed beds;

116.19 (6) the savings from not paying planned closure rate adjustments that the facilities would
116.20 otherwise be eligible for under section ~~256B.437~~ 256R.40; and

116.21 (7) the savings from not paying external fixed costs payment rate adjustments from
116.22 submission of renovation costs that would otherwise be eligible as threshold projects under
116.23 section 256B.434, subdivision 4f.

116.24 (c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical
116.25 assistance resident days of the remaining facility or facilities shall be computed assuming
116.26 95 percent occupancy multiplied by the historical percentage of medical assistance resident
116.27 days of the remaining facility or facilities, as reported on the facility's or facilities' most
116.28 recent nursing facility statistical and cost report filed before the plan of closure is submitted,
116.29 multiplied by 365.

116.30 (d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy
116.31 percentages will be those reported on the facility's or facilities' most recent nursing facility
116.32 statistical and cost report filed before the plan of closure is submitted, and the average

117.1 payment rates shall be calculated based on the approved payment rates in effect at the time
117.2 the consolidation request is submitted.

117.3 (e) To qualify for the external fixed costs payment rate adjustment under this subdivision,
117.4 the closing facilities shall:

117.5 (1) submit an application for closure according to section ~~256B.437, subdivision 3~~
117.6 256R.40, subdivision 2; and

117.7 (2) follow the resident relocation provisions of section 144A.161.

117.8 (f) The county or counties in which a facility or facilities are closed under this subdivision
117.9 shall not be eligible for designation as a hardship area under subdivision 3 for five years
117.10 from the date of the approval of the proposed consolidation. The applicant shall notify the
117.11 county of this limitation and the county shall acknowledge this in a letter of support.

117.12 **EFFECTIVE DATE.** This section is effective for consolidations occurring after July
117.13 1, 2017.

117.14 Sec. 5. Minnesota Statutes 2016, section 144A.74, is amended to read:

117.15 **144A.74 MAXIMUM CHARGES.**

117.16 A supplemental nursing services agency must not bill or receive payments from a nursing
117.17 home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted
117.18 average wage rate, plus a factor determined by the commissioner to incorporate payroll
117.19 taxes as defined in ~~Minnesota Rules, part 9549.0020, subpart 33~~ section 256R.02, subdivision
117.20 37, for the applicable employee classification for the geographic group ~~to which the nursing~~
117.21 ~~home is assigned under Minnesota Rules, part 9549.0052~~ specified in section 256R.23,
117.22 subdivision 4. The weighted average wage rates must be determined by the commissioner
117.23 of human services and reported to the commissioner of health on an annual basis. Wages
117.24 are defined as hourly rate of pay and shift differential, including weekend shift differential
117.25 and overtime. Facilities shall provide information necessary to determine weighted average
117.26 wage rates to the commissioner of human services in a format requested by the commissioner.
117.27 The maximum rate must include all charges for administrative fees, contract fees, or other
117.28 special charges in addition to the hourly rates for the temporary nursing pool personnel
117.29 supplied to a nursing home. A nursing home that pays for the actual travel and housing costs
117.30 for supplemental nursing services agency staff working at the facility and that pays these
117.31 costs to the employee, the agency, or another vendor, is not violating the limitation on
117.32 charges described in this section.

117.33 **EFFECTIVE DATE.** This section is effective the day following final enactment.

118.1 Sec. 6. Minnesota Statutes 2016, section 256.975, subdivision 7, is amended to read:

118.2 Subd. 7. **Consumer information and assistance and long-term care options**

118.3 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a

118.4 statewide service to aid older Minnesotans and their families in making informed choices

118.5 about long-term care options and health care benefits. Language services to persons with

118.6 limited English language skills may be made available. The service, known as Senior

118.7 LinkAge Line, shall serve older adults as the designated Aging and Disability Resource

118.8 Center under United States Code, title 42, section 3001, the Older Americans Act

118.9 Amendments of 2006 in partnership with the Disability Linkage Line under section 256.01,

118.10 subdivision 24, and must be available during business hours through a statewide toll-free

118.11 number and the Internet. The Minnesota Board on Aging shall consult with, and when

118.12 appropriate work through, the area agencies on aging counties, and other entities that serve

118.13 aging and disabled populations of all ages, to provide and maintain the telephone

118.14 infrastructure and related support for the Aging and Disability Resource Center partners

118.15 which agree by memorandum to access the infrastructure, including the designated providers

118.16 of the Senior LinkAge Line and the Disability Linkage Line.

118.17 (b) The service must provide long-term care options counseling by assisting older adults,

118.18 caregivers, and providers in accessing information and options counseling about choices in

118.19 long-term care services that are purchased through private providers or available through

118.20 public options. The service must:

118.21 (1) develop and provide for regular updating of a comprehensive database that includes

118.22 detailed listings in both consumer- and provider-oriented formats that can provide search

118.23 results down to the neighborhood level;

118.24 (2) make the database accessible on the Internet and through other telecommunication

118.25 and media-related tools;

118.26 (3) link callers to interactive long-term care screening tools and make these tools available

118.27 through the Internet by integrating the tools with the database;

118.28 (4) develop community education materials with a focus on planning for long-term care

118.29 and evaluating independent living, housing, and service options;

118.30 (5) conduct an outreach campaign to assist older adults and their caregivers in finding

118.31 information on the Internet and through other means of communication;

118.32 (6) implement a messaging system for overflow callers and respond to these callers by

118.33 the next business day;

119.1 (7) link callers with county human services and other providers to receive more in-depth
119.2 assistance and consultation related to long-term care options;

119.3 (8) link callers with quality profiles for nursing facilities and other home and
119.4 community-based services providers developed by the commissioners of health and human
119.5 services;

119.6 (9) develop an outreach plan to seniors and their caregivers with a particular focus on
119.7 establishing a clear presence in places that seniors recognize and:

119.8 (i) place a significant emphasis on improved outreach and service to seniors and their
119.9 caregivers by establishing annual plans by neighborhood, city, and county, as necessary, to
119.10 address the unique needs of geographic areas in the state where there are dense populations
119.11 of seniors;

119.12 (ii) establish an efficient workforce management approach and assign community living
119.13 specialist staff and volunteers to geographic areas as well as aging and disability resource
119.14 center sites so that seniors and their caregivers and professionals recognize the Senior
119.15 LinkAge Line as the place to call for aging services and information;

119.16 (iii) recognize the size and complexity of the metropolitan area service system by working
119.17 with metropolitan counties to establish a clear partnership with them, including seeking
119.18 county advice on the establishment of local aging and disabilities resource center sites; and

119.19 (iv) maintain dashboards with metrics that demonstrate how the service is expanding
119.20 and extending or enhancing its outreach efforts in dispersed or hard to reach locations in
119.21 varied population centers;

119.22 (10) incorporate information about the availability of housing options, as well as
119.23 registered housing with services and consumer rights within the MinnesotaHelp.info network
119.24 long-term care database to facilitate consumer comparison of services and costs among
119.25 housing with services establishments and with other in-home services and to support financial
119.26 self-sufficiency as long as possible. Housing with services establishments and their arranged
119.27 home care providers shall provide information that will facilitate price comparisons, including
119.28 delineation of charges for rent and for services available. The commissioners of health and
119.29 human services shall align the data elements required by section 144G.06, the Uniform
119.30 Consumer Information Guide, and this section to provide consumers standardized information
119.31 and ease of comparison of long-term care options. The commissioner of human services
119.32 shall provide the data to the Minnesota Board on Aging for inclusion in the
119.33 MinnesotaHelp.info network long-term care database;

120.1 (11) provide long-term care options counseling. Long-term care options counselors shall:

120.2 (i) for individuals not eligible for case management under a public program or public
120.3 funding source, provide interactive decision support under which consumers, family
120.4 members, or other helpers are supported in their deliberations to determine appropriate
120.5 long-term care choices in the context of the consumer's needs, preferences, values, and
120.6 individual circumstances, including implementing a community support plan;

120.7 (ii) provide Web-based educational information and collateral written materials to
120.8 familiarize consumers, family members, or other helpers with the long-term care basics,
120.9 issues to be considered, and the range of options available in the community;

120.10 (iii) provide long-term care futures planning, which means providing assistance to
120.11 individuals who anticipate having long-term care needs to develop a plan for the more
120.12 distant future; and

120.13 (iv) provide expertise in benefits and financing options for long-term care, including
120.14 Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages,
120.15 private pay options, and ways to access low or no-cost services or benefits through
120.16 volunteer-based or charitable programs;

120.17 (12) using risk management and support planning protocols, provide long-term care
120.18 options counseling under clause (13) to current residents of nursing homes deemed
120.19 appropriate for discharge by the commissioner, ~~former residents of nursing homes who~~
120.20 ~~were discharged to community settings, and older adults who request service after~~
120.21 ~~consultation with the Senior LinkAge Line under clause (13). The Senior LinkAge Line~~
120.22 ~~shall also receive referrals from the residents or staff of nursing homes.~~ who meet a profile
120.23 that demonstrates that the consumer is either at risk of readmission to a nursing home or
120.24 hospital, or would benefit from long-term care options counseling to age in place. The Senior
120.25 LinkAge Line shall identify and contact residents or patients deemed appropriate ~~for~~
120.26 ~~discharge~~ by developing targeting criteria and creating a profile in consultation with the
120.27 commissioner ~~who~~. The commissioner shall provide designated Senior LinkAge Line contact
120.28 centers with a list of current or former nursing home residents or people discharged from a
120.29 hospital or for whom Medicare home care has ended, that meet the criteria as being
120.30 appropriate for ~~discharge planning~~ long-term care options counseling through a referral via
120.31 a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a
120.32 preference to receive long-term care options counseling, with initial assessment and, if
120.33 appropriate, a referral to:

120.34 (i) long-term care consultation services under section 256B.0911;

121.1 (ii) designated care coordinators of contracted entities under section 256B.035 for persons
121.2 who are enrolled in a managed care plan; or

121.3 (iii) the long-term care consultation team for those who are eligible for relocation service
121.4 coordination due to high-risk factors or psychological or physical disability; and

121.5 (13) develop referral protocols and processes that will assist certified health care homes,
121.6 Medicare home care, and hospitals to identify at-risk older adults and determine when to
121.7 refer these individuals to the Senior LinkAge Line for long-term care options counseling
121.8 under this section. The commissioner is directed to work with the commissioner of health
121.9 to develop protocols that would comply with the health care home designation criteria and
121.10 protocols available at the time of hospital discharge or the end of Medicare home care. The
121.11 commissioner shall keep a record of the number of people who choose long-term care
121.12 options counseling as a result of this section.

121.13 (c) Nursing homes shall provide contact information to the Senior LinkAge Line for
121.14 residents identified in paragraph (b), clause (12), to provide long-term care options counseling
121.15 pursuant to paragraph (b), clause (11). The contact information for residents shall include
121.16 all information reasonably necessary to contact residents, including first and last names,
121.17 permanent and temporary addresses, telephone numbers, and e-mail addresses.

121.18 (d) The Senior LinkAge Line shall determine when it is appropriate to refer a consumer
121.19 who receives long-term care options counseling under paragraph (b), clause (12) or (13),
121.20 and who uses an unpaid caregiver to the self-directed caregiver service under subdivision
121.21 12.

121.22 **EFFECTIVE DATE.** This section is effective July 1, 2017.

121.23 Sec. 7. Minnesota Statutes 2016, section 256.975, is amended by adding a subdivision to
121.24 read:

121.25 Subd. 12. **Self-directed caregiver grants.** Beginning on July 1, 2019, the Minnesota
121.26 Board on Aging shall administer self-directed caregiver grants to support at risk family
121.27 caregivers of older adults or others eligible under the Older Americans Act of 1965, United
121.28 States Code, title 42, chapter 35, sections 3001 to 3058ff, to sustain family caregivers in
121.29 the caregivers' roles so older adults can remain at home longer. The board shall give priority
121.30 to consumers referred under section 256.975, subdivision 7, paragraph (d).

121.31 **EFFECTIVE DATE.** This section is effective July 1, 2017.

122.1 Sec. 8. [256.9755] CAREGIVER SUPPORT PROGRAMS.

122.2 Subdivision 1. Program goals. It is the goal of all area agencies on aging and caregiver
122.3 support programs to support family caregivers of persons with Alzheimer's disease or other
122.4 related dementias who are living in the community by:

122.5 (1) promoting caregiver support programs that serve Minnesotans in their homes and
122.6 communities; and

122.7 (2) providing, within the limits of available funds, the caregiver support services that
122.8 will enable the family caregiver to access caregiver support programs in the most
122.9 cost-effective and efficient manner.

122.10 Subd. 2. Authority. The Minnesota Board on Aging shall allocate to area agencies on
122.11 aging the state and federal funds which are received for the caregiver support program in a
122.12 manner consistent with federal requirements.

122.13 Subd. 3. Caregiver support services. Funds allocated to an area agency on aging for
122.14 caregiver support services must be used in a manner consistent with the National Family
122.15 Caregiver Support Program to reach family caregivers of persons with Alzheimer's disease
122.16 or related dementias. The funds must be used to provide social, nonmedical,
122.17 community-based services and activities that provide respite for caregivers and social
122.18 interaction for participants.

122.19 Sec. 9. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

122.20 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
122.21 planning, or other assistance intended to support community-based living, including persons
122.22 who need assessment in order to determine waiver or alternative care program eligibility,
122.23 must be visited by a long-term care consultation team within 20 calendar days after the date
122.24 on which an assessment was requested or recommended. Upon statewide implementation
122.25 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
122.26 requesting personal care assistance services and home care nursing. The commissioner shall
122.27 provide at least a 90-day notice to lead agencies prior to the effective date of this requirement.
122.28 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

122.29 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
122.30 assessors to conduct the assessment. For a person with complex health care needs, a public
122.31 health or registered nurse from the team must be consulted.

122.32 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
122.33 be used to complete a comprehensive, person-centered assessment. The assessment must

123.1 include the health, psychological, functional, environmental, and social needs of the
123.2 individual necessary to develop a community support plan that meets the individual's needs
123.3 and preferences.

123.4 (d) The assessment must be conducted in a face-to-face interview with the person being
123.5 assessed and the person's legal representative. At the request of the person, other individuals
123.6 may participate in the assessment to provide information on the needs, strengths, and
123.7 preferences of the person necessary to develop a community support plan that ensures the
123.8 person's health and safety. Except for legal representatives or family members invited by
123.9 the person, persons participating in the assessment may not be a provider of service or have
123.10 any financial interest in the provision of services. For persons who are to be assessed for
123.11 elderly waiver customized living or adult day services under section 256B.0915, with the
123.12 permission of the person being assessed or the person's designated or legal representative,
123.13 the client's current or proposed provider of services may submit a copy of the provider's
123.14 nursing assessment or written report outlining its recommendations regarding the client's
123.15 care needs. The person conducting the assessment must notify the provider of the date by
123.16 which this information is to be submitted. This information shall be provided to the person
123.17 conducting the assessment prior to the assessment. For a person who is to be assessed for
123.18 waiver services under section 256B.092 or 256B.49, with the permission of the person being
123.19 assessed or the person's designated legal representative, the person's current provider of
123.20 services may submit a written report outlining recommendations regarding the person's care
123.21 needs prepared by a direct service employee with at least 20 hours of service to that client.
123.22 The person conducting the assessment or reassessment must notify the provider of the date
123.23 by which this information is to be submitted. This information shall be provided to the
123.24 person conducting the assessment and the person or the person's legal representative, and
123.25 must be considered prior to the finalization of the assessment or reassessment.

123.26 (e) The person or the person's legal representative must be provided with a written
123.27 community support plan within 40 calendar days of the assessment visit, regardless of
123.28 whether the individual is eligible for Minnesota health care programs.

123.29 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
123.30 provider who submitted information under paragraph (d) shall receive a copy of the
123.31 assessment, the final written community support plan when available, the case mix level,
123.32 and the Residential Services Workbook.

123.33 (g) The written community support plan must include:

123.34 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

124.1 (2) the individual's options and choices to meet identified needs, including all available
124.2 options for case management services and providers;

124.3 (3) identification of health and safety risks and how those risks will be addressed,
124.4 including personal risk management strategies;

124.5 (4) referral information; and

124.6 (5) informal caregiver supports, if applicable.

124.7 For a person determined eligible for state plan home care under subdivision 1a, paragraph
124.8 (b), clause (1), the person or person's representative must also receive a copy of the home
124.9 care service plan developed by the certified assessor.

124.10 ~~(f)~~ (h) A person may request assistance in identifying community supports without
124.11 participating in a complete assessment. Upon a request for assistance identifying community
124.12 support, the person must be transferred or referred to long-term care options counseling
124.13 services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for
124.14 telephone assistance and follow up.

124.15 ~~(g)~~ (i) The person has the right to make the final decision between institutional placement
124.16 and community placement after the recommendations have been provided, except as provided
124.17 in section 256.975, subdivision 7a, paragraph (d).

124.18 ~~(h)~~ (j) The lead agency must give the person receiving assessment or support planning,
124.19 or the person's legal representative, materials, and forms supplied by the commissioner
124.20 containing the following information:

124.21 (1) written recommendations for community-based services and consumer-directed
124.22 options;

124.23 (2) documentation that the most cost-effective alternatives available were offered to the
124.24 individual. For purposes of this clause, "cost-effective" means community services and
124.25 living arrangements that cost the same as or less than institutional care. For an individual
124.26 found to meet eligibility criteria for home and community-based service programs under
124.27 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
124.28 approved waiver plan for each program;

124.29 (3) the need for and purpose of preadmission screening conducted by long-term care
124.30 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
124.31 nursing facility placement. If the individual selects nursing facility placement, the lead
124.32 agency shall forward information needed to complete the level of care determinations and

- 125.1 screening for developmental disability and mental illness collected during the assessment
125.2 to the long-term care options counselor using forms provided by the commissioner;
- 125.3 (4) the role of long-term care consultation assessment and support planning in eligibility
125.4 determination for waiver and alternative care programs, and state plan home care, case
125.5 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
125.6 and (b);
- 125.7 (5) information about Minnesota health care programs;
- 125.8 (6) the person's freedom to accept or reject the recommendations of the team;
- 125.9 (7) the person's right to confidentiality under the Minnesota Government Data Practices
125.10 Act, chapter 13;
- 125.11 (8) the certified assessor's decision regarding the person's need for institutional level of
125.12 care as determined under criteria established in subdivision 4e and the certified assessor's
125.13 decision regarding eligibility for all services and programs as defined in subdivision 1a,
125.14 paragraphs (a), clause (6), and (b); and
- 125.15 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
125.16 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
125.17 (8), and (b), and incorporating the decision regarding the need for institutional level of care
125.18 or the lead agency's final decisions regarding public programs eligibility according to section
125.19 256.045, subdivision 3.
- 125.20 ~~(j)~~ (k) Face-to-face assessment completed as part of eligibility determination for the
125.21 alternative care, elderly waiver, community access for disability inclusion, community
125.22 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,
125.23 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after
125.24 the date of assessment.
- 125.25 ~~(j)~~ (l) The effective eligibility start date for programs in paragraph ~~(j)~~(k) can never be
125.26 prior to the date of assessment. If an assessment was completed more than 60 days before
125.27 the effective waiver or alternative care program eligibility start date, assessment and support
125.28 plan information must be updated and documented in the department's Medicaid Management
125.29 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
125.30 state plan services, the effective date of eligibility for programs included in paragraph ~~(j)~~
125.31 (k) cannot be prior to the date the most recent updated assessment is completed.
- 125.32 (m) If an eligibility update is completed within 90 days of the previous face-to-face
125.33 assessment and documented in the department's Medicaid Management Information System

126.1 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
126.2 of the previous face-to-face assessment when all other eligibility requirements are met.

126.3 Sec. 10. Minnesota Statutes 2016, section 256B.0915, subdivision 3a, is amended to read:

126.4 Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal
126.5 year in which the resident assessment system as described in section ~~256B.438~~ 256R.17 for
126.6 nursing home rate determination is implemented and the first day of each subsequent state
126.7 fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver
126.8 client shall be the monthly limit of the case mix resident class to which the waiver client
126.9 would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the
126.10 last day of the previous state fiscal year, adjusted by any legislatively adopted home and
126.11 community-based services percentage rate adjustment. If a legislatively authorized increase
126.12 is service-specific, the monthly cost limit shall be adjusted based on the overall average
126.13 increase to the elderly waiver program.

126.14 (b) The monthly limit for the cost of waived services under paragraph (a) to an
126.15 individual elderly waiver client assigned to a case mix classification A with:

126.16 (1) no dependencies in activities of daily living; or

126.17 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating when
126.18 the dependency score in eating is three or greater as determined by an assessment performed
126.19 under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new
126.20 participants enrolled in the program on or after July 1, 2011. This monthly limit shall be
126.21 applied to all other participants who meet this criteria at reassessment. This monthly limit
126.22 shall be increased annually as described in paragraphs (a) and (e).

126.23 (c) If extended medical supplies and equipment or environmental modifications are or
126.24 will be purchased for an elderly waiver client, the costs may be prorated for up to 12
126.25 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's
126.26 waived services exceeds the monthly limit established in paragraph (a), (b), (d), or (e),
126.27 the annual cost of all waived services shall be determined. In this event, the annual cost
126.28 of all waived services shall not exceed 12 times the monthly limit of waived services
126.29 as described in paragraph (a), (b), (d), or (e).

126.30 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including any
126.31 necessary home care services described in section 256B.0651, subdivision 2, for individuals
126.32 who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1,
126.33 paragraph (g), shall be the average of the monthly medical assistance amount established

127.1 for home care services as described in section 256B.0652, subdivision 7, and the annual
 127.2 average contracted amount established by the commissioner for nursing facility services
 127.3 for ventilator-dependent individuals. This monthly limit shall be increased annually as
 127.4 described in paragraphs (a) and (e).

127.5 (e) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, the monthly
 127.6 cost limits for elderly waiver services in effect on the previous ~~June 30~~ December 31 shall
 127.7 be increased by the difference between any legislatively adopted home and community-based
 127.8 provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and
 127.9 the average statewide percentage increase in nursing facility operating payment rates under
 127.10 ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January
 127.11 1. This paragraph shall only apply if the average statewide percentage increase in nursing
 127.12 facility operating payment rates is greater than any legislatively adopted home and
 127.13 community-based provider rate increases effective on ~~July~~ January 1, or occurring since
 127.14 the previous ~~July~~ January 1.

127.15 Sec. 11. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

127.16 Subd. 3e. **Customized living service rate.** (a) Payment for customized living services
 127.17 shall be a monthly rate authorized by the lead agency within the parameters established by
 127.18 the commissioner. The payment agreement must delineate the amount of each component
 127.19 service included in the recipient's customized living service plan. The lead agency, with
 127.20 input from the provider of customized living services, shall ensure that there is a documented
 127.21 need within the parameters established by the commissioner for all component customized
 127.22 living services authorized.

127.23 (b) The payment rate must be based on the amount of component services to be provided
 127.24 utilizing component rates established by the commissioner. Counties and tribes shall use
 127.25 tools issued by the commissioner to develop and document customized living service plans
 127.26 and rates.

127.27 (c) Component service rates must not exceed payment rates for comparable elderly
 127.28 waiver or medical assistance services and must reflect economies of scale. Customized
 127.29 living services must not include rent or raw food costs.

127.30 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
 127.31 individualized monthly authorized payment for the customized living service plan shall not
 127.32 exceed 50 percent of the ~~greater of either the statewide or any of the geographic groups'~~
 127.33 weighted average monthly nursing facility rate of the case mix resident class to which the
 127.34 elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051

128.1 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph
 128.2 (a). ~~Effective On July 1 of the state fiscal~~ each year in which the resident assessment system
 128.3 ~~as described in section 256B.438 for nursing home rate determination is implemented and~~
 128.4 ~~July 1 of each subsequent state fiscal year~~, the individualized monthly authorized payment
 128.5 for the services described in this clause shall not exceed the limit which was in effect on
 128.6 June 30 of the previous state fiscal year updated annually based on legislatively adopted
 128.7 changes to all service rate maximums for home and community-based service providers.

128.8 (e) For rates effective on or after January 1, 2022, the elderly waiver payment for
 128.9 customized living services includes a cognitive and behavioral needs factor equal to an
 128.10 additional 15 percent applied to the component service rates for a client:

128.11 (1) for whom the total monthly hours for customized living services divided by 30.4 is
 128.12 less than 3.62; and

128.13 (2) who is determined, based on responses to questions 45 and 51 of the Minnesota
 128.14 long-term care consultation assessment form, to have either:

128.15 (i) wandering or orientation issues; or

128.16 (ii) anxiety, verbal aggression, physical aggression, repetitive behavior, agitation,
 128.17 self-injurious behavior, or behavior related to property destruction.

128.18 ~~(e) Effective July 1, 2011,~~ (f) The individualized monthly payment for the customized
 128.19 living service plan for individuals described in subdivision 3a, paragraph (b), must be the
 128.20 monthly authorized payment limit for customized living for individuals classified as case
 128.21 mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled
 128.22 in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a,
 128.23 paragraph (b). This monthly limit also applies to all other participants who meet the criteria
 128.24 described in subdivision 3a, paragraph (b), at reassessment.

128.25 ~~(f)~~ (g) Customized living services are delivered by a provider licensed by the Department
 128.26 of Health as a class A or class F home care provider and provided in a building that is
 128.27 registered as a housing with services establishment under chapter 144D. Licensed home
 128.28 care providers are subject to section 256B.0651, subdivision 14.

128.29 ~~(g)~~ (h) A provider may not bill or otherwise charge an elderly waiver participant or their
 128.30 family for additional units of any allowable component service beyond those available under
 128.31 the service rate limits described in paragraph ~~(d)~~ (e), nor for additional units of any allowable
 128.32 component service beyond those approved in the service plan by the lead agency.

129.1 ~~(h)~~ (i) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter,
 129.2 individualized service rate limits for customized living services under this subdivision shall
 129.3 be increased by the difference between any legislatively adopted home and community-based
 129.4 provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and
 129.5 the average statewide percentage increase in nursing facility operating payment rates under
 129.6 ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January
 129.7 1. This paragraph shall only apply if the average statewide percentage increase in nursing
 129.8 facility operating payment rates is greater than any legislatively adopted home and
 129.9 community-based provider rate increases effective on ~~July~~ January 1, or occurring since
 129.10 the previous ~~July~~ January 1.

129.11 **EFFECTIVE DATE.** This section prevails over any conflicting amendment regardless
 129.12 of the order of enactment.

129.13 Sec. 12. Minnesota Statutes 2016, section 256B.0915, subdivision 3h, is amended to read:

129.14 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment
 129.15 rate for 24-hour customized living services is a monthly rate authorized by the lead agency
 129.16 within the parameters established by the commissioner of human services. The payment
 129.17 agreement must delineate the amount of each component service included in each recipient's
 129.18 customized living service plan. The lead agency, with input from the provider of customized
 129.19 living services, shall ensure that there is a documented need within the parameters established
 129.20 by the commissioner for all component customized living services authorized. The lead
 129.21 agency shall not authorize 24-hour customized living services unless there is a documented
 129.22 need for 24-hour supervision.

129.23 (b) For purposes of this section, "24-hour supervision" means that the recipient requires
 129.24 assistance due to needs related to one or more of the following:

129.25 (1) intermittent assistance with toileting, positioning, or transferring;

129.26 (2) cognitive or behavioral issues;

129.27 (3) a medical condition that requires clinical monitoring; or

129.28 (4) for all new participants enrolled in the program on or after July 1, 2011, and all other
 129.29 participants at their first reassessment after July 1, 2011, dependency in at least three of the
 129.30 following activities of daily living as determined by assessment under section 256B.0911:
 129.31 bathing; dressing; grooming; walking; or eating when the dependency score in eating is
 129.32 three or greater; and needs medication management and at least 50 hours of service per
 129.33 month. The lead agency shall ensure that the frequency and mode of supervision of the

130.1 recipient and the qualifications of staff providing supervision are described and meet the
130.2 needs of the recipient.

130.3 (c) The payment rate for 24-hour customized living services must be based on the amount
130.4 of component services to be provided utilizing component rates established by the
130.5 commissioner. Counties and tribes will use tools issued by the commissioner to develop
130.6 and document customized living plans and authorize rates.

130.7 (d) Component service rates must not exceed payment rates for comparable elderly
130.8 waiver or medical assistance services and must reflect economies of scale.

130.9 (e) The individually authorized 24-hour customized living payments, in combination
130.10 with the payment for other elderly waiver services, including case management, must not
130.11 exceed the recipient's community budget cap specified in subdivision 3a. Customized living
130.12 services must not include rent or raw food costs.

130.13 (f) The individually authorized 24-hour customized living payment rates shall not exceed
130.14 the 95 percentile of statewide monthly authorizations for 24-hour customized living services
130.15 in effect and in the Medicaid management information systems on March 31, 2009, for each
130.16 case mix resident class under Minnesota Rules, parts 9549.0051 to 9549.0059, to which
130.17 elderly waiver service clients are assigned. When there are fewer than 50 authorizations in
130.18 effect in the case mix resident class, the commissioner shall multiply the calculated service
130.19 payment rate maximum for the A classification by the standard weight for that classification
130.20 under Minnesota Rules, parts 9549.0051 to 9549.0059, to determine the applicable payment
130.21 rate maximum. Service payment rate maximums shall be updated annually based on
130.22 legislatively adopted changes to all service rates for home and community-based service
130.23 providers.

130.24 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may
130.25 establish alternative payment rate systems for 24-hour customized living services in housing
130.26 with services establishments which are freestanding buildings with a capacity of 16 or fewer,
130.27 by applying a single hourly rate for covered component services provided in either:

130.28 (1) licensed corporate adult foster homes; or

130.29 (2) specialized dementia care units which meet the requirements of section 144D.065
130.30 and in which:

130.31 (i) each resident is offered the option of having their own apartment; or

131.1 (ii) the units are licensed as board and lodge establishments with maximum capacity of
131.2 eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
131.3 subparts 1, 2, 3, and 4, item A.

131.4 (h) Twenty-four-hour customized living services are delivered by a provider licensed
131.5 by the Department of Health as a class A or class F home care provider and provided in a
131.6 building that is registered as a housing with services establishment under chapter 144D.
131.7 Licensed home care providers are subject to section 256B.0651, subdivision 14.

131.8 (i) A provider may not bill or otherwise charge an elderly waiver participant or their
131.9 family for additional units of any allowable component service beyond those available under
131.10 the service rate limits described in paragraph (e), nor for additional units of any allowable
131.11 component service beyond those approved in the service plan by the lead agency.

131.12 (j) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter,
131.13 individualized service rate limits for 24-hour customized living services under this
131.14 subdivision shall be increased by the difference between any legislatively adopted home
131.15 and community-based provider rate increases effective on ~~July~~ January 1 or since the previous
131.16 ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating
131.17 payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective
131.18 the previous January 1. This paragraph shall only apply if the average statewide percentage
131.19 increase in nursing facility operating payment rates is greater than any legislatively adopted
131.20 home and community-based provider rate increases effective on ~~July~~ January 1, or occurring
131.21 since the previous ~~July~~ January 1.

131.22 Sec. 13. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

131.23 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall
131.24 receive an initial assessment of strengths, informal supports, and need for services in
131.25 accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client
131.26 served under the elderly waiver must be conducted at least every 12 months ~~and at other~~
131.27 ~~times when the case manager determines that there has been significant change in the client's~~
131.28 ~~functioning. This may include instances where the client is discharged from the hospital.~~
131.29 There must be a determination that the client requires nursing facility level of care as defined
131.30 in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and
131.31 maintain participation in the waiver program.

131.32 (b) Regardless of other assessments identified in section 144.0724, subdivision 4, as
131.33 appropriate to determine nursing facility level of care for purposes of medical assistance
131.34 payment for nursing facility services, only face-to-face assessments conducted according

132.1 to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care
132.2 determination will be accepted for purposes of initial and ongoing access to waiver service
132.3 payment.

132.4 (c) The lead agency shall conduct a change-in-condition reassessment before the annual
132.5 reassessment in cases where a client's condition changed due to a major health event, an
132.6 emerging need or risk, worsening health condition, or cases where the current services do
132.7 not meet the client's needs. A change-in-condition reassessment may be initiated by the lead
132.8 agency, or it may be requested by the client or requested on the client's behalf by another
132.9 party, such as a provider of services. The lead agency shall complete a change-in-condition
132.10 reassessment no later than 20 calendar days from the request. The lead agency shall conduct
132.11 these assessments in a timely manner and expedite urgent requests. The lead agency shall
132.12 evaluate urgent requests based on the client's needs and risk to the client if a reassessment
132.13 is not completed.

132.14 Sec. 14. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
132.15 to read:

132.16 Subd. 11. **Payment rates; application.** The payment methodologies in subdivisions 12
132.17 to 16 apply to elderly waiver and elderly waiver customized living under this section,
132.18 alternative care under section 256B.0913, essential community supports under section
132.19 256B.0922, and community access for disability inclusion customized living, brain injury
132.20 customized living, and elderly waiver foster care and residential care.

132.21 Sec. 15. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
132.22 to read:

132.23 Subd. 12. **Payment rates; phase-in.** (a) Effective January 1, 2019, through December
132.24 31, 2020, all rates and rate components for services under subdivision 11 shall be the sum
132.25 of 12 percent of the rates calculated under subdivisions 13 to 16 and 88 percent of the rates
132.26 calculated using the rate methodology in effect as of June 30, 2017.

132.27 (b) Effective January 1, 2021, all rates and rate components for services under subdivision
132.28 11 shall be the sum of 20 percent of the rates calculated under subdivisions 13 to 16 and 80
132.29 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

133.1 Sec. 16. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
133.2 to read:

133.3 Subd. 13. **Payment rates; establishment.** (a) The commissioner shall use standard
133.4 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in
133.5 the most recent edition of the Occupational Handbook and data from the most recent and
133.6 available nursing facility cost report, to establish rates and component rates every January
133.7 1 using Minnesota-specific wages taken from job descriptions.

133.8 (b) In creating the rates and component rates, the commissioner shall establish a base
133.9 wage calculation for each component service and value, and add the following factors:

133.10 (1) payroll taxes and benefits;

133.11 (2) general and administrative;

133.12 (3) program plan support;

133.13 (4) registered nurse management and supervision; and

133.14 (5) social worker supervision.

133.15 Sec. 17. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
133.16 to read:

133.17 Subd. 14. **Payment rates; base wage index.** (a) Base wages are calculated for customized
133.18 living, foster care, and residential care component services as follows:

133.19 (1) the home management and support services base wage equals 33.33 percent of the
133.20 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
133.21 care aide (SOC code 39-9021); 33.33 percent of the Minneapolis-St. Paul-Bloomington,
133.22 MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and
133.23 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage
133.24 for maids and housekeeping cleaners (SOC code 37-2012);

133.25 (2) the home care aide base wage equals 50 percent of the Minneapolis-St.
133.26 Paul-Bloomington, MN-WI MetroSA average wage for home health aides (SOC code
133.27 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
133.28 average wage for nursing assistants (SOC code 31-1014);

133.29 (3) the home health aide base wage equals 20 percent of the Minneapolis-St.
133.30 Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed
133.31 vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.

134.1 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
134.2 31-1014); and

134.3 (4) the medication setups by licensed practical nurse base wage equals ten percent of
134.4 the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
134.5 and licensed vocational nurses (SOC code 29-2061); and 90 percent of the Minneapolis-St.
134.6 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
134.7 29-1141).

134.8 (b) Base wages are calculated for the following services as follows:

134.9 (1) the chore services base wage equals 100 percent of the Minneapolis-St.
134.10 Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping
134.11 workers (SOC code 37-3011);

134.12 (2) the companion services base wage equals 50 percent of the Minneapolis-St.
134.13 Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aides (SOC
134.14 code 39-9021); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
134.15 average wage for maids and housekeeping cleaners (SOC code 37-2012);

134.16 (3) the homemaker services and assistance with personal care base wage equals 60
134.17 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for
134.18 personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St.
134.19 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
134.20 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
134.21 average wage for maids and housekeeping cleaners (SOC code 37-2012);

134.22 (4) the homemaker services and cleaning base wage equals 60 percent of the
134.23 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
134.24 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
134.25 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
134.26 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
134.27 housekeeping cleaners (SOC code 37-2012);

134.28 (5) the homemaker services and home management base wage equals 60 percent of the
134.29 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
134.30 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
134.31 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
134.32 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
134.33 housekeeping cleaners (SOC code 37-2012);

135.1 (6) the in-home respite care services base wage equals five percent of the Minneapolis-St.
 135.2 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
 135.3 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average
 135.4 wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St.
 135.5 Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed
 135.6 vocational nurses (SOC code 29-2061);

135.7 (7) the out-of-home respite care services base wage equals five percent of the
 135.8 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses
 135.9 (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
 135.10 average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
 135.11 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
 135.12 and licensed vocational nurses (SOC code 29-2061); and

135.13 (8) the individual community living support base wage equals 20 percent of the
 135.14 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
 135.15 and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.
 135.16 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
 135.17 31-1014).

135.18 (c) Base wages are calculated for the following values as follows:

135.19 (1) the registered nurse base wage equals 100 percent of the Minneapolis-St.
 135.20 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
 135.21 29-1141); and

135.22 (2) the social worker base wage equals 100 percent of the Minneapolis-St.
 135.23 Paul-Bloomington, MN-WI MetroSA average wage for medical and public health social
 135.24 workers (SOC code 21-1022).

135.25 (d) If any of the SOC codes and positions are no longer available, the commissioner
 135.26 shall, in consultation with stakeholders, select a new SOC code and position that is the
 135.27 closest match to the previously used SOC position.

135.28 Sec. 18. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
 135.29 to read:

135.30 Subd. 15. **Payment rates; factors.** The commissioner shall use the following factors:

135.31 (1) the payroll taxes and benefits factor is the sum of net payroll taxes and benefits
 135.32 divided by the sum of all salaries for all nursing facilities on the most recent and available
 135.33 cost report;

136.1 (2) the general and administrative factor is the sum of net general and administrative
136.2 expenses minus administrative salaries divided by total operating expenses for all nursing
136.3 facilities on the most recent and available cost report;

136.4 (3) the program plan support factor is defined as the direct service staff needed to provide
136.5 support for the home and community-based service when not engaged in direct contact with
136.6 clients. Based on the 2016 Non-Wage Provider Costs in Home and Community-Based
136.7 Disability Waiver Services Report, this factor equals 12.8 percent;

136.8 (4) the registered nurse management and supervision factor equals 15 percent of the
136.9 product of the position's base wage and the sum of the factors in clauses (1) to (3); and

136.10 (5) the social worker supervision factor equals 15 percent of the product of the position's
136.11 base wage and the sum of the factors in clauses (1) to (3).

136.12 Sec. 19. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
136.13 to read:

136.14 Subd. 16. **Payment rates; component rates.** (a) For the purposes of this subdivision,
136.15 the "adjusted base wage" for a position equals the position's base wage plus:

136.16 (1) the position's base wage multiplied by the payroll taxes and benefits factor;

136.17 (2) the position's base wage multiplied by the general and administrative factor; and

136.18 (3) the position's base wage multiplied by the program plan support factor.

136.19 (b) For medication setups by licensed nurse, registered nurse, and social worker services,
136.20 the component rate for each service equals the respective position's adjusted base wage.

136.21 (c) For home management and support services, home care aide, and home health aide
136.22 services, the component rate for each service equals the respective position's adjusted base
136.23 wage plus the registered nurse management and supervision factor.

136.24 (d) The home management and support services component rate shall be used for payment
136.25 for socialization and transportation component rates under elderly waiver customized living.

136.26 (e) The 15-minute unit rates for chore services and companion services are calculated
136.27 as follows:

136.28 (1) sum the adjusted base wage for the respective position and the social worker factor;
136.29 and

136.30 (2) divide the result of clause (1) by four.

137.1 (f) The 15-minute unit rates for homemaker services and assistance with personal care,
137.2 homemaker services and cleaning, and homemaker services and home management are
137.3 calculated as follows:

137.4 (1) sum the adjusted base wage for the respective position and the registered nurse
137.5 management and supervision factor; and

137.6 (2) divide the result of clause (1) by four.

137.7 (g) The 15-minute unit rate for in-home respite care services is calculated as follows:

137.8 (1) sum the adjusted base wage for in-home respite care services and the registered nurse
137.9 management and supervision factor; and

137.10 (2) divide the result of clause (1) by four.

137.11 (h) The in-home respite care services daily rate equals the in-home respite care services
137.12 15-minute unit rate multiplied by 18.

137.13 (i) The 15-minute unit rate for out-of-home respite care is calculated as follows:

137.14 (1) sum the out-of-home respite care services adjusted base wage and the registered
137.15 nurse management and supervision factor; and

137.16 (2) divide the result of clause (1) by four.

137.17 (j) The out-of-home respite care services daily rate equals the out-of-home respite care
137.18 services 15-minute unit rate multiplied by 18.

137.19 (k) The individual community living support rate is calculated as follows:

137.20 (1) sum the adjusted base wage for the home care aide rate in subdivision 14, paragraph
137.21 (a), clause (2), and the social worker factor; and

137.22 (2) divide the result of clause (1) by four.

137.23 (l) The home delivered meals rate equals \$9.30. Beginning July 1, 2018, the commissioner
137.24 shall increase the home delivered meals rate every July 1 by the percent increase in the
137.25 nursing facility dietary per diem using the two most recent nursing facility cost reports.

137.26 (m) The adult day services rate is based on the home care aide rate in subdivision 14,
137.27 paragraph (a), clause (2), plus the additional factors from subdivision 15, except that the
137.28 general and administrative factor used shall be 20 percent. The nonregistered nurse portion
137.29 of the rate shall be multiplied by 0.25, to reflect an assumed-ratio staffing of one caregiver
137.30 to four clients, and divided by four to determine the 15-minute unit rate. The registered

138.1 nurse portion is divided by four to determine the 15-minute unit rate and \$0.63 per 15-minute
 138.2 unit is added to cover the cost of meals.

138.3 (n) The adult day services bath 15-minute unit rate is the same as the calculation of the
 138.4 adult day services 15-minute unit rate without the adjustment for staffing ratio.

138.5 (o) If a bath is authorized for an adult day services client, at least two 15-minute units
 138.6 must be authorized to allow for adequate time to meet client needs. Adult day services may
 138.7 be authorized for up to 48 units, or 12 hours, per day based on client and family caregiver
 138.8 needs.

138.9 Sec. 20. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
 138.10 to read:

138.11 Subd. 17. **Evaluation of rate methodology.** The commissioner, in consultation with
 138.12 stakeholders, shall conduct a study to evaluate the following:

138.13 (1) base wages in subdivision 14, to determine if the standard occupational classification
 138.14 codes for each rate and component rate are an appropriate representation of staff who deliver
 138.15 the services; and

138.16 (2) factors in subdivision 15, and adjusted base wage calculation in subdivision 16, to
 138.17 determine if the factors and calculations appropriately address nonwage provider costs.

138.18 By January 1, 2019, the commissioner shall submit a report to the legislature on the
 138.19 changes to the rate methodology in this statute, based on the results of the evaluation. Where
 138.20 feasible, the report shall address the impact of the new rates on the workforce situation and
 138.21 client access to services. The report should include any changes to the rate calculations
 138.22 methods that the commissioner recommends.

138.23 Sec. 21. Minnesota Statutes 2016, section 256B.0922, subdivision 1, is amended to read:

138.24 **Subdivision 1. Essential community supports.** (a) The purpose of the essential
 138.25 community supports program is to provide targeted services to persons age 65 and older
 138.26 who need essential community support, but whose needs do not meet the level of care
 138.27 required for nursing facility placement under section 144.0724, subdivision 11.

138.28 (b) Essential community supports are available not to exceed ~~\$400~~ \$600 per person per
 138.29 month. Essential community supports may be used as authorized within an authorization
 138.30 period not to exceed 12 months. Services must be available to a person who:

138.31 (1) is age 65 or older;

- 139.1 (2) is not eligible for medical assistance;
- 139.2 (3) has received a community assessment under section 256B.0911, subdivision 3a or
139.3 3b, and does not require the level of care provided in a nursing facility;
- 139.4 (4) meets the financial eligibility criteria for the alternative care program under section
139.5 256B.0913, subdivision 4;
- 139.6 (5) has a community support plan; and
- 139.7 (6) has been determined by a community assessment under section 256B.0911,
139.8 subdivision 3a or 3b, to be a person who would require provision of at least one of the
139.9 following services, as defined in the approved elderly waiver plan, in order to maintain their
139.10 community residence:
- 139.11 (i) adult day services;
- 139.12 (ii) family caregiver support services;
- 139.13 (iii) respite care;
- 139.14 ~~(iii)~~ (iv) homemaker support;
- 139.15 (v) companion services;
- 139.16 ~~(iv)~~ (vi) chores;
- 139.17 ~~(v)~~ (vii) a personal emergency response device or system;
- 139.18 ~~(vi)~~ (viii) home-delivered meals; or
- 139.19 ~~(vii)~~ (ix) community living assistance as defined by the commissioner.
- 139.20 (c) The person receiving any of the essential community supports in this subdivision
139.21 must also receive service coordination, not to exceed \$600 in a 12-month authorization
139.22 period, as part of their community support plan.
- 139.23 (d) A person who has been determined to be eligible for essential community supports
139.24 must be reassessed at least annually and continue to meet the criteria in paragraph (b) to
139.25 remain eligible for essential community supports.
- 139.26 (e) The commissioner is authorized to use federal matching funds for essential community
139.27 supports as necessary and to meet demand for essential community supports as outlined in
139.28 subdivision 2, and that amount of federal funds is appropriated to the commissioner for this
139.29 purpose.

140.1 Sec. 22. Minnesota Statutes 2016, section 256B.431, subdivision 10, is amended to read:

140.2 Subd. 10. **Property rate adjustments and construction projects.** A nursing facility
140.3 completing a construction project that is eligible for a rate adjustment under section
140.4 256B.434, subdivision 4f, and that was not approved through the moratorium exception
140.5 process in section 144A.073 must request from the commissioner a property-related payment
140.6 rate adjustment. ~~If the request is made within 60 days after the construction project's~~
140.7 ~~completion date,~~ The effective date of the rate adjustment is the first of the month of January
140.8 or July, whichever occurs first following both the construction project's completion date
140.9 and submission of the provider's rate adjustment request. ~~If the request is made more than~~
140.10 ~~60 days after the completion date, the rate adjustment is effective on the first of the month~~
140.11 ~~following the request.~~ The commissioner shall provide a rate notice reflecting the allowable
140.12 costs within 60 days after receiving all the necessary information to compute the rate
140.13 adjustment. No sooner than the effective date of the rate adjustment for the construction
140.14 project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any
140.15 amounts collected from private pay residents in excess of the allowable rate must be repaid
140.16 to private pay residents with interest at the rate used by the commissioner of revenue for
140.17 the late payment of taxes and in effect on the date the rate increase is effective. Construction
140.18 projects with completion dates within one year of the completion date associated with the
140.19 property rate adjustment request and phased projects with project completion dates within
140.20 three years of the last phase of the phased project must be aggregated for purposes of the
140.21 minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section
140.22 144A.071, subdivision 2. "Construction project" and "project construction costs" have the
140.23 meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

140.24 **EFFECTIVE DATE.** This section is effective for projects completed after January 1,
140.25 2018.

140.26 Sec. 23. Minnesota Statutes 2016, section 256B.431, subdivision 16, is amended to read:

140.27 Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning
140.28 after June 30, 1993, if a nursing facility acquires capital assets in connection with a project
140.29 approved under the moratorium exception process in section 144A.073 or in connection
140.30 with an addition to or replacement of buildings, attached fixtures, or land improvements
140.31 for which the total historical cost of those capital asset additions exceeds the lesser of
140.32 \$150,000 or ten percent of the most recent appraised value, the nursing facility shall be
140.33 eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation

141.1 is separate from the determination of the nursing facility's rental rate. An equity incentive
141.2 payment rate as computed under this subdivision is limited to one in a 12-month period.

141.3 (a) An eligible nursing facility shall receive an equity incentive payment rate equal to
141.4 the allowable historical cost of the capital asset acquired, minus the allowable debt directly
141.5 identified to that capital asset, multiplied by the equity incentive factor as described in
141.6 paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under
141.7 subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total
141.8 payment rate and shall be effective the same day as the incremental increase in paragraph
141.9 (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable
141.10 debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080,
141.11 and this section.

141.12 (b) The equity incentive factor shall be determined under clauses (1) to (4):

141.13 (1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the
141.14 capital asset additions referred to in paragraph (a), then cube the quotient,

141.15 (2) subtract the amount calculated in clause (1) from the number one,

141.16 (3) determine the difference between the rental factor and the lesser of two percentage
141.17 points above the posted yield for standard conventional fixed rate mortgages of the Federal
141.18 Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on
141.19 the first day of the month the debt or cost is incurred, or 16 percent,

141.20 (4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

141.21 (c) The equity incentive payment rate shall be limited to the term of the allowable debt
141.22 in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in
141.23 acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The
141.24 sale of a nursing facility under subdivision 14 shall terminate application of the equity
141.25 incentive payment rate effective on the date provided in subdivision 14, paragraph (f), for
141.26 the sale.

141.27 (d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures,
141.28 or land improvements meeting the criteria in this subdivision and not receiving the
141.29 property-related payment rate adjustment in subdivision 17, shall receive the incremental
141.30 increase in the nursing facility's rental rate as determined under Minnesota Rules, parts
141.31 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the
141.32 nursing facility's property-related payment rate. The effective date of this incremental

142.1 increase shall be the first day of the month of January or July, whichever occurs first
142.2 following the ~~month in~~ date on which the addition or replacement is completed.

142.3 **EFFECTIVE DATE.** This section is effective for additions or replacements completed
142.4 after January 1, 2018.

142.5 Sec. 24. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

142.6 Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July
142.7 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway
142.8 shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph
142.9 (c), and calculation of the rental per diem, have those beds given the same effect as if the
142.10 beds had been delicensed so long as the beds remain on layaway. At the time of a layaway,
142.11 a facility may change its single bed election for use in calculating capacity days under
142.12 Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be
142.13 effective the first day of the month of January or July, whichever occurs first following the
142.14 ~~month in~~ date on which the layaway of the beds becomes effective under section 144A.071,
142.15 subdivision 4b.

142.16 (b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to
142.17 the contrary under section 256B.434, a nursing facility reimbursed under that section ~~which~~
142.18 that has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed
142.19 to:

142.20 (1) aggregate the applicable investment per bed limits based on the number of beds
142.21 licensed immediately prior to entering the alternative payment system;

142.22 (2) retain or change the facility's single bed election for use in calculating capacity days
142.23 under Minnesota Rules, part 9549.0060, subpart 11; and

142.24 (3) establish capacity days based on the number of beds immediately prior to the layaway
142.25 and the number of beds after the layaway.

142.26 The commissioner shall increase the facility's property payment rate by the incremental
142.27 increase in the rental per diem resulting from the recalculation of the facility's rental per
142.28 diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and
142.29 (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
142.30 project after its base year, the base year property rate shall be the moratorium project property
142.31 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
142.32 paragraph (c). The property payment rate increase shall be effective the first day of the

143.1 month of January or July, whichever occurs first following the ~~month in~~ date on which the
143.2 layaway of the beds becomes effective.

143.3 (c) If a nursing facility removes a bed from layaway status in accordance with section
143.4 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the
143.5 number of licensed and certified beds in the facility not on layaway and shall reduce the
143.6 nursing facility's property payment rate in accordance with paragraph (b).

143.7 (d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision
143.8 to the contrary under section 256B.434, a nursing facility reimbursed under that section,
143.9 ~~which~~ that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the
143.10 commissioner of health according to the notice requirements in section 144A.071, subdivision
143.11 4b, shall be allowed to:

143.12 (1) aggregate the applicable investment per bed limits based on the number of beds
143.13 licensed immediately prior to entering the alternative payment system;

143.14 (2) retain or change the facility's single bed election for use in calculating capacity days
143.15 under Minnesota Rules, part 9549.0060, subpart 11; and

143.16 (3) establish capacity days based on the number of beds immediately prior to the
143.17 delicensure and the number of beds after the delicensure.

143.18 The commissioner shall increase the facility's property payment rate by the incremental
143.19 increase in the rental per diem resulting from the recalculation of the facility's rental per
143.20 diem applying only the changes resulting from the delicensure of beds and clauses (1), (2),
143.21 and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
143.22 project after its base year, the base year property rate shall be the moratorium project property
143.23 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
143.24 paragraph (c). The property payment rate increase shall be effective the first day of the
143.25 month of January or July, whichever occurs first following the ~~month in~~ date on which the
143.26 delicensure of the beds becomes effective.

143.27 (e) For nursing facilities reimbursed under this section or section 256B.434, any beds
143.28 placed on layaway shall not be included in calculating facility occupancy as it pertains to
143.29 leave days defined in Minnesota Rules, part 9505.0415.

143.30 (f) For nursing facilities reimbursed under this section or section 256B.434, the rental
143.31 rate calculated after placing beds on layaway may not be less than the rental rate prior to
143.32 placing beds on layaway.

144.1 (g) A nursing facility receiving a rate adjustment as a result of this section shall comply
 144.2 with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

144.3 (h) A facility that does not utilize the space made available as a result of bed layaway
 144.4 or delicensure under this subdivision to reduce the number of beds per room or provide
 144.5 more common space for nursing facility uses or perform other activities related to the
 144.6 operation of the nursing facility shall have its property rate increase calculated under this
 144.7 subdivision reduced by the ratio of the square footage made available that is not used for
 144.8 these purposes to the total square footage made available as a result of bed layaway or
 144.9 delicensure.

144.10 **EFFECTIVE DATE.** This section is effective for layaways occurring after July 1, 2017.

144.11 Sec. 25. Minnesota Statutes 2016, section 256B.434, subdivision 4, is amended to read:

144.12 Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning
 144.13 on and after January 1, 2019, a nursing facility's ~~ease mix~~ property payment ~~rates~~ rate for
 144.14 the second and subsequent years of a facility's contract under this section are the previous
 144.15 rate year's ~~contract~~ property payment ~~rates~~ rate plus an inflation adjustment ~~and, for facilities~~
 144.16 ~~reimbursed under this section or section 256B.431, an adjustment to include the cost of any~~
 144.17 ~~increase in Health Department licensing fees for the facility taking effect on or after July~~
 144.18 ~~1, 2001.~~ The index for the inflation adjustment must be based on the change in the Consumer
 144.19 Price Index-All Items (United States City average) (CPI-U) forecasted by the ~~commissioner~~
 144.20 ~~of management and budget's national economic consultant~~ Reports and Forecasts Division
 144.21 of the Department of Human Services, as forecasted in the fourth quarter of the calendar
 144.22 year preceding the rate year. The inflation adjustment must be based on the 12-month period
 144.23 from the midpoint of the previous rate year to the midpoint of the rate year for which the
 144.24 rate is being determined. ~~For the rate years beginning on July 1, 1999, July 1, 2000, July 1,~~
 144.25 ~~2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July~~
 144.26 ~~1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the~~
 144.27 ~~property-related payment rate. For the rate years beginning on October 1, 2011, October 1,~~
 144.28 ~~2012, October 1, 2013, October 1, 2014, October 1, 2015, January 1, 2016, and January 1,~~
 144.29 ~~2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005,~~
 144.30 ~~adjustment to the property payment rate under this section and section 256B.431 shall be~~
 144.31 ~~effective on October 1. In determining the amount of the property-related payment rate~~
 144.32 ~~adjustment under this paragraph, the commissioner shall determine the proportion of the~~
 144.33 ~~facility's rates that are property-related based on the facility's most recent cost report.~~

144.34 **EFFECTIVE DATE.** This section is effective the day following final enactment.

145.1 Sec. 26. Minnesota Statutes 2016, section 256B.434, subdivision 4f, is amended to read:

145.2 Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a)

145.3 Effective October 1, 2006, facilities reimbursed under this section may receive a property
145.4 rate adjustment for construction projects exceeding the threshold in section 256B.431,
145.5 subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For
145.6 these projects, capital assets purchased shall be counted as construction project costs for a
145.7 rate adjustment request made by a facility if they are: (1) purchased within 24 months of
145.8 the completion of the construction project; (2) purchased after the completion date of any
145.9 prior construction project; and (3) are not purchased prior to July 14, 2005. Except as
145.10 otherwise provided in this subdivision, the definitions, rate calculation methods, and
145.11 principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to
145.12 9549.0080, shall be used to calculate rate adjustments for allowable construction projects
145.13 under this subdivision and section 144A.073. Facilities completing construction projects
145.14 between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment
145.15 effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible
145.16 for a property rate adjustment effective on the first day of the month following the completion
145.17 date. Facilities completing projects after January 1, 2018, are eligible for a property rate
145.18 adjustment effective on the first day of the month of January or July, whichever occurs
145.19 immediately following the completion date.

145.20 (b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under
145.21 section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a
145.22 construction project on or after October 1, 2004, and do not have a contract under subdivision
145.23 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431,
145.24 subdivision 10, through September 30, 2006. If the request results in the commissioner
145.25 determining a rate adjustment is allowable, the rate adjustment is effective on the first of
145.26 the month following project completion. These facilities shall be allowed to accumulate
145.27 construction project costs for the period October 1, 2004, to September 30, 2006.

145.28 (c) Facilities shall be allowed construction project rate adjustments no sooner than 12
145.29 months after completing a previous construction project. Facilities must request the rate
145.30 adjustment according to section 256B.431, subdivision 10.

145.31 (d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060,
145.32 subpart 11. For rate calculations under this section, the number of licensed beds in the
145.33 nursing facility shall be the number existing after the construction project is completed and
145.34 the number of days in the nursing facility's reporting period shall be 365.

146.1 (e) The value of assets to be recognized for a total replacement project as defined in
146.2 section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value
146.3 of assets to be recognized for all other projects shall be computed as described in clause
146.4 (2).

146.5 (1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
146.6 number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the
146.7 maximum amount of assets allowable in a facility's property rate calculation. If a facility's
146.8 current request for a rate adjustment results from the completion of a construction project
146.9 that was previously approved under section 144A.073, the assets to be used in the rate
146.10 calculation cannot exceed the lesser of the amount determined under sections 144A.071,
146.11 subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction
146.12 project. A current request that is not the result of a project under section 144A.073 cannot
146.13 exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits
146.14 must be deducted from the cost of the construction project.

146.15 (2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
146.16 number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be
146.17 used to compute the maximum amount of assets allowable in a facility's property rate
146.18 calculation.

146.19 (ii) The value of a facility's assets to be compared to the amount in item (i) begins with
146.20 the total appraised value from the last rate notice a facility received when its rates were set
146.21 under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value
146.22 shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each
146.23 rate year the facility received an inflation factor on its property-related rate when its rates
146.24 were set under this section. The value of assets listed as previous capital additions, capital
146.25 additions, and special projects on the facility's base year rate notice and the value of assets
146.26 related to a construction project for which the facility received a rate adjustment when its
146.27 rates were determined under this section shall be added to the indexed appraised value.

146.28 (iii) The maximum amount of assets to be recognized in computing a facility's rate
146.29 adjustment after a project is completed is the lesser of the aggregate replacement-cost-new
146.30 limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the
146.31 construction project.

146.32 (iv) If a facility's current request for a rate adjustment results from the completion of a
146.33 construction project that was previously approved under section 144A.073, the assets to be
146.34 added to the rate calculation cannot exceed the lesser of the amount determined under

147.1 sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable
147.2 costs of the construction project. A current request that is not the result of a project under
147.3 section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2,
147.4 paragraph (a). Assets disposed of as a result of a construction project and applicable credits
147.5 must be deducted from the cost of the construction project.

147.6 (f) For construction projects approved under section 144A.073, allowable debt may
147.7 never exceed the lesser of the cost of the assets purchased, the threshold limit in section
147.8 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital
147.9 debt.

147.10 (g) For construction projects that were not approved under section 144A.073, allowable
147.11 debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such
147.12 construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously
147.13 existing capital debt. Amounts of debt taken out that exceed the costs of a construction
147.14 project shall not be allowed regardless of the use of the funds.

147.15 For all construction projects being recognized, interest expense and average debt shall
147.16 be computed based on the first 12 months following project completion. "Previously existing
147.17 capital debt" means capital debt recognized on the last rate determined under section
147.18 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt
147.19 recognized for a construction project for which the facility received a rate adjustment when
147.20 its rates were determined under this section.

147.21 For a total replacement project as defined in section 256B.431, subdivision 17d, the
147.22 value of previously existing capital debt shall be zero.

147.23 (h) In addition to the interest expense allowed from the application of paragraph (f), the
147.24 amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and
147.25 (3), will be added to interest expense.

147.26 (i) The equity portion of the construction project shall be computed as the allowable
147.27 assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be
147.28 multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added.
147.29 This sum must be divided by 95 percent of capacity days to compute the construction project
147.30 rate adjustment.

147.31 (j) For projects that are not a total replacement of a nursing facility, the amount in
147.32 paragraph (i) is adjusted for nonreimbursable areas and then added to the current property
147.33 payment rate of the facility.

148.1 (k) For projects that are a total replacement of a nursing facility, the amount in paragraph
 148.2 (i) becomes the new property payment rate after being adjusted for nonreimbursable areas.
 148.3 Any amounts existing in a facility's rate before the effective date of the construction project
 148.4 for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements
 148.5 under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431,
 148.6 subdivision 19, shall be removed from the facility's rates.

148.7 (l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060,
 148.8 subpart 10, as the result of construction projects under this section. Allowable equipment
 148.9 shall be included in the construction project costs.

148.10 (m) Capital assets purchased after the completion date of a construction project shall be
 148.11 counted as construction project costs for any future rate adjustment request made by a facility
 148.12 under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months
 148.13 of the completion of the future construction project.

148.14 (n) In subsequent rate years, the property payment rate for a facility that results from
 148.15 the application of this subdivision shall be the amount inflated in subdivision 4.

148.16 (o) Construction projects are eligible for an equity incentive under section 256B.431,
 148.17 subdivision 16. When computing the equity incentive for a construction project under this
 148.18 subdivision, only the allowable costs and allowable debt related to the construction project
 148.19 shall be used. The equity incentive shall not be a part of the property payment rate and not
 148.20 inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing
 148.21 facilities reimbursed under this section shall be allowed for a duration determined under
 148.22 section 256B.431, subdivision 16, paragraph (c).

148.23 **EFFECTIVE DATE.** This section is effective January 1, 2018.

148.24 Sec. 27. Minnesota Statutes 2016, section 256B.50, subdivision 1b, is amended to read:

148.25 Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a
 148.26 written notice of appeal; the appeal must be postmarked or received by the commissioner
 148.27 within 60 days of the publication date ~~the determination of the payment rate was mailed or~~
 148.28 ~~personally received by a provider, whichever is earlier~~ printed on the rate notice. The notice
 148.29 of appeal must specify each disputed item; the reason for the dispute; the total dollar amount
 148.30 in dispute for each separate disallowance, allocation, or adjustment of each cost item or part
 148.31 of a cost item; the computation that the provider believes is correct; the authority in statute
 148.32 or rule upon which the provider relies for each disputed item; the name and address of the

149.1 person or firm with whom contacts may be made regarding the appeal; and other information
 149.2 required by the commissioner.

149.3 **EFFECTIVE DATE.** This section is effective the day following final enactment.

149.4 Sec. 28. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision
 149.5 to read:

149.6 Subd. 3a. **Therapeutic leave days.** Notwithstanding Minnesota Rules, part 9505.0415,
 149.7 subpart 7, a vacant bed in an intermediate care facility for persons with developmental
 149.8 disabilities shall be counted as a reserved bed when determining occupancy rates and
 149.9 eligibility for payment of a therapeutic leave day.

149.10 Sec. 29. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision
 149.11 to read:

149.12 Subd. 17. **ICF/DD rate increase effective July 1, 2017; Murray County.** Effective
 149.13 July 1, 2017, the daily rate for an intermediate care facility for persons with developmental
 149.14 disabilities located in Murray County that is classified as a class B facility and licensed for
 149.15 14 beds is \$400. This increase is in addition to any other increase that is effective on July
 149.16 1, 2017.

149.17 Sec. 30. Minnesota Statutes 2016, section 256R.02, subdivision 4, is amended to read:

149.18 Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for
 149.19 administering the overall activities of the nursing home. These costs include salaries and
 149.20 wages of the administrator, assistant administrator, business office employees, security
 149.21 guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related
 149.22 to business office functions, licenses, ~~and~~ permits except as provided in the external fixed
 149.23 costs category, employee recognition, travel including meals and lodging, all training except
 149.24 as specified in subdivision 17, voice and data communication or transmission, office supplies,
 149.25 property and liability insurance and other forms of insurance ~~not designated to other areas~~
 149.26 except insurance that is a fringe benefit under subdivision 22, personnel recruitment, legal
 149.27 services, accounting services, management or business consultants, data processing,
 149.28 information technology, Web site, central or home office costs, business meetings and
 149.29 seminars, postage, fees for professional organizations, subscriptions, security services,
 149.30 advertising, board of directors fees, working capital interest expense, ~~and~~ bad debts, ~~and~~
 149.31 bad debt collection fees, and costs incurred for travel and housing for persons employed by
 149.32 a supplemental nursing services agency as defined in section 144A.70, subdivision 6.

150.1 **EFFECTIVE DATE.** This section is effective October 1, 2017.

150.2 Sec. 31. Minnesota Statutes 2016, section 256R.02, subdivision 17, is amended to read:

150.3 Subd. 17. **Direct care costs.** "Direct care costs" means costs for the wages of nursing
 150.4 administration, direct care registered nurses, licensed practical nurses, certified nursing
 150.5 assistants, trained medication aides, employees conducting training in resident care topics
 150.6 and associated fringe benefits and payroll taxes; services from a supplemental nursing
 150.7 services agency; supplies that are stocked at nursing stations or on the floor and distributed
 150.8 or used individually, including, but not limited to: alcohol, applicators, cotton balls,
 150.9 incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue
 150.10 depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers,
 150.11 plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes,
 150.12 clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee
 150.13 schedule by the medical assistance program or any other payer, and technology related to
 150.14 the provision of nursing care to residents, such as electronic charting systems; costs of
 150.15 materials used for resident care training, and training courses outside of the facility attended
 150.16 by direct care staff on resident care topics; and costs for nurse consultants, pharmacy
 150.17 consultants, and medical directors. Salaries and payroll taxes for nurse consultants who
 150.18 work out of a central office must be allocated proportionately by total resident days or by
 150.19 direct identification to the nursing facilities served by those consultants.

150.20 Sec. 32. Minnesota Statutes 2016, section 256R.02, subdivision 18, is amended to read:

150.21 Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means
 150.22 premium expenses for group coverage ~~and reinsurance;~~₂ actual expenses incurred for
 150.23 self-insured plans, including reinsurance; and employer contributions to employee health
 150.24 reimbursement and health savings accounts. Premium and expense costs and contributions
 150.25 are allowable for (1) all employees and (2) the spouse and dependents of those employees
 150.26 ~~who meet the definition of full-time employees under the federal Affordable Care Act,~~
 150.27 ~~Public Law 111-148~~ are employed on average at least 30 hours per week.

150.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

150.29 Sec. 33. Minnesota Statutes 2016, section 256R.02, subdivision 19, is amended to read:

150.30 Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing
 150.31 home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122;
 150.32 family advisory council fee under section 144A.33; scholarships under section 256R.37;

151.1 planned closure rate adjustments under section 256R.40; consolidation rate adjustments
 151.2 under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d;
 151.3 single-bed room incentives under section 256R.41; property taxes, assessments, and payments
 151.4 in lieu of taxes; employer health insurance costs; quality improvement incentive payment
 151.5 rate adjustments under section 256R.39; performance-based incentive payments under
 151.6 section 256R.38; special dietary needs under section 256R.51; rate adjustments for
 151.7 compensation-related costs for minimum wage changes under section 256R.49 provided
 151.8 on or after January 1, 2018; and Public Employees Retirement Association employer costs.

151.9 Sec. 34. Minnesota Statutes 2016, section 256R.02, subdivision 22, is amended to read:

151.10 Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life,
 151.11 dental, workers' compensation, ~~and other employee insurances and~~ short- and long-term
 151.12 disability, long-term care insurance, accident insurance, supplemental insurance, legal
 151.13 assistance insurance, profit sharing, health insurance costs not covered under subdivision
 151.14 18, including costs associated with part-time employee family members or retirees, and
 151.15 pension and retirement plan contributions, except for the Public Employees Retirement
 151.16 Association ~~and employer health insurance costs; profit sharing; and retirement plans for~~
 151.17 ~~which the employer pays all or a portion of the costs.~~

151.18 Sec. 35. Minnesota Statutes 2016, section 256R.02, subdivision 42, is amended to read:

151.19 Subd. 42. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing
 151.20 facility residents and the allocation of dietary credits. Also included are special dietary
 151.21 supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

151.22 Sec. 36. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision
 151.23 to read:

151.24 Subd. 42a. **Real estate taxes.** "Real estate taxes" means the real estate tax liability shown
 151.25 on the annual property tax statement of the nursing facility for the reporting period. The
 151.26 term does not include personnel costs or fees for late payment.

151.27 Sec. 37. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision
 151.28 to read:

151.29 Subd. 48a. **Special assessments.** "Special assessments" means the actual special
 151.30 assessments and related interest paid during the reporting period. The term does not include
 151.31 personnel costs or fees for late payment.

152.1 Sec. 38. Minnesota Statutes 2016, section 256R.02, subdivision 52, is amended to read:

152.2 Subd. 52. **Therapy costs.** "Therapy costs" means any costs related to ~~medical assistance~~
152.3 therapy services provided to residents that are not billed separately billable from the daily
152.4 operating rate.

152.5 Sec. 39. Minnesota Statutes 2016, section 256R.06, subdivision 5, is amended to read:

152.6 Subd. 5. **Notice to residents.** (a) No increase in nursing facility rates for private paying
152.7 residents shall be effective unless the nursing facility notifies the resident or person
152.8 responsible for payment of the increase in writing 30 days before the increase takes effect.
152.9 The notice must include the amount of the rate increase, the new payment rate, and the date
152.10 the rate increase takes effect.

152.11 A nursing facility may adjust its rates without giving the notice required by this
152.12 subdivision when the purpose of the rate adjustment is to reflect a change in the case mix
152.13 classification of the resident. The nursing facility shall notify private pay residents of any
152.14 rate increase related to a change in case mix classifications in a timely manner after
152.15 confirmation of the case mix classification change is received from the Department of
152.16 Health.

152.17 If the state fails to set rates as required by section 256R.09, subdivision 1, the time
152.18 required for giving notice is decreased by the number of days by which the state was late
152.19 in setting the rates.

152.20 (b) If the state does not set rates by the date required in section 256R.09, subdivision 1,
152.21 or otherwise provides nursing facilities with retroactive notification of the amount of a rate
152.22 increase, nursing facilities shall meet the requirement for advance notice by informing the
152.23 resident or person responsible for payments, on or before the effective date of the increase,
152.24 that a rate increase will be effective on that date. The requirements of paragraph (a) do not
152.25 apply to situations described in this paragraph.

152.26 If the exact amount has not yet been determined, the nursing facility may raise the rates
152.27 by the amount anticipated to be allowed. Any amounts collected from private pay residents
152.28 in excess of the allowable rate must be repaid to private pay residents with interest at the
152.29 rate used by the commissioner of revenue for the late payment of taxes and in effect on the
152.30 date the rate increase is effective.

153.1 Sec. 40. Minnesota Statutes 2016, section 256R.07, is amended by adding a subdivision
153.2 to read:

153.3 Subd. 6. **Electronic signature.** For documentation requiring a signature under this
153.4 chapter or section 256B.431 or 256B.434, use of an electronic signature as defined under
153.5 section 325L.02, paragraph (h), is allowed.

153.6 Sec. 41. Minnesota Statutes 2016, section 256R.10, is amended by adding a subdivision
153.7 to read:

153.8 Subd. 7. **Not specified allowed costs.** When the cost category for allowed cost items or
153.9 services is not specified in this chapter or the provider reimbursement manual, the
153.10 commissioner, in consultation with stakeholders, shall determine the cost category for the
153.11 allowed cost item or service.

153.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

153.13 Sec. 42. **[256R.18] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

153.14 Beginning January 1, 2019, the commissioner shall provide to the house of representatives
153.15 and senate committees with jurisdiction over nursing facility payment rates a biennial report
153.16 on the effectiveness of the reimbursement system in improving quality, restraining costs,
153.17 and any other features of the system as determined by the commissioner.

153.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.

153.19 Sec. 43. Minnesota Statutes 2016, section 256R.37, is amended to read:

153.20 **256R.37 SCHOLARSHIPS.**

153.21 (a) For the 27-month period beginning October 1, 2015, through December 31, 2017,
153.22 the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing
153.23 facility with no scholarship per diem that is requesting a scholarship per diem to be added
153.24 to the external fixed payment rate to be used:

153.25 (1) for employee scholarships that satisfy the following requirements:

153.26 (i) scholarships are available to all employees who work an average of at least ten hours
153.27 per week at the facility except the administrator, and to reimburse student loan expenses
153.28 for newly hired ~~and recently graduated~~ registered nurses and licensed practical nurses, and
153.29 training expenses for nursing assistants as specified in section 144A.611, subdivisions 2
153.30 and 4, who are newly hired ~~and have graduated within the last 12 months~~; and

154.1 (ii) the course of study is expected to lead to career advancement with the facility or in
154.2 long-term care, including medical care interpreter services and social work; and

154.3 (2) to provide job-related training in English as a second language.

154.4 (b) All facilities may annually request a rate adjustment under this section by submitting
154.5 information to the commissioner on a schedule and in a form supplied by the commissioner.
154.6 The commissioner shall allow a scholarship payment rate equal to the reported and allowable
154.7 costs divided by resident days.

154.8 (c) In calculating the per diem under paragraph (b), the commissioner shall allow costs
154.9 related to tuition, direct educational expenses, and reasonable costs as defined by the
154.10 commissioner for child care costs and transportation expenses related to direct educational
154.11 expenses.

154.12 (d) The rate increase under this section is an optional rate add-on that the facility must
154.13 request from the commissioner in a manner prescribed by the commissioner. The rate
154.14 increase must be used for scholarships as specified in this section.

154.15 (e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities
154.16 that close beds during a rate year may request to have their scholarship adjustment under
154.17 paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect
154.18 the reduction in resident days compared to the cost report year.

154.19 Sec. 44. Minnesota Statutes 2016, section 256R.40, subdivision 1, is amended to read:

154.20 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

154.21 (b) "Closure" means the cessation of operations of a nursing facility and delicensure and
154.22 decertification of all beds within the facility.

154.23 (c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of
154.24 the resulting savings to provide planned closure rate adjustments at other facilities.

154.25 (d) "Commencement of closure" means the date on which residents and designated
154.26 representatives are notified of a planned closure as provided in section 144A.161, subdivision
154.27 5a, as part of an approved closure plan.

154.28 (e) "Completion of closure" means the date on which the final resident of the nursing
154.29 facility designated for closure in an approved closure plan is discharged from the facility
154.30 or the date that beds from a partial closure are delicensed and decertified.

154.31 (f) "Partial closure" means the delicensure and decertification of a portion of the beds
154.32 within the facility.

155.1 (g) "Planned closure rate adjustment" means an increase in a nursing facility's operating
155.2 rates resulting from a planned closure or a planned partial closure of another facility.

155.3 Sec. 45. Minnesota Statutes 2016, section 256R.40, subdivision 5, is amended to read:

155.4 Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the
155.5 amount of the planned closure rate adjustment available under subdivision 6 according to
155.6 clauses (1) to (4):

155.7 (1) the amount available is the net reduction of nursing facility beds multiplied by \$2,080;

155.8 (2) the total number of beds in the nursing facility or facilities receiving the planned
155.9 closure rate adjustment must be identified;

155.10 (3) capacity days are determined by multiplying the number determined under clause
155.11 (2) by 365; and

155.12 (4) the planned closure rate adjustment is the amount available in clause (1), divided by
155.13 capacity days determined under clause (3).

155.14 (b) A planned closure rate adjustment under this section is effective on the first day of
155.15 the month of January or July, whichever occurs immediately following completion of closure
155.16 of the facility designated for closure in the application and becomes part of the nursing
155.17 facility's external fixed payment rate.

155.18 (c) Upon the request of a closing facility, the commissioner must allow the facility a
155.19 closure rate adjustment as provided under section 144A.161, subdivision 10.

155.20 (d) A facility that has received a planned closure rate adjustment may reassign it to
155.21 another facility that is under the same ownership at any time within three years of its effective
155.22 date. The amount of the adjustment is computed according to paragraph (a).

155.23 (e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the
155.24 commissioner shall recalculate planned closure rate adjustments for facilities that delicense
155.25 beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar
155.26 amount. The recalculated planned closure rate adjustment is effective from the date the per
155.27 bed dollar amount is increased.

155.28 **EFFECTIVE DATE.** This section is effective for closures occurring after July 1, 2017.

155.29 Sec. 46. Minnesota Statutes 2016, section 256R.41, is amended to read:

155.30 **256R.41 SINGLE-BED ROOM INCENTIVE.**

156.1 (a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed
 156.2 under this chapter shall be increased by 20 percent multiplied by the ratio of the number of
 156.3 new single-bed rooms created divided by the number of active beds on July 1, 2005, for
 156.4 each bed closure that results in the creation of a single-bed room after July 1, 2005. The
 156.5 commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each
 156.6 year. For eligible bed closures for which the commissioner receives a notice from a facility
 156.7 ~~during a calendar quarter~~ that a bed has been delicensed and a new single-bed room has
 156.8 been established, the rate adjustment in this paragraph shall be effective on either the first
 156.9 day of the ~~second~~ month of January or July, whichever occurs first following ~~that calendar~~
 156.10 ~~quarter~~ the date of the bed delicensure.

156.11 (b) A nursing facility is prohibited from discharging residents for purposes of establishing
 156.12 single-bed rooms. A nursing facility must submit documentation to the commissioner in a
 156.13 form prescribed by the commissioner, certifying the occupancy status of beds closed to
 156.14 create single-bed rooms. In the event that the commissioner determines that a facility has
 156.15 discharged a resident for purposes of establishing a single-bed room, the commissioner shall
 156.16 not provide a rate adjustment under paragraph (a).

156.17 **EFFECTIVE DATE.** This section is effective for closures occurring after July 1, 2017.

156.18 Sec. 47. Minnesota Statutes 2016, section 256R.47, is amended to read:

156.19 **256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING**
 156.20 **FACILITIES.**

156.21 (a) The commissioner, in consultation with the commissioner of health, may designate
 156.22 certain nursing facilities as critical access nursing facilities. The designation shall be granted
 156.23 on a competitive basis, within the limits of funds appropriated for this purpose.

156.24 (b) The commissioner shall request proposals from nursing facilities every two years.
 156.25 Proposals must be submitted in the form and according to the timelines established by the
 156.26 commissioner. In selecting applicants to designate, the commissioner, in consultation with
 156.27 the commissioner of health, and with input from stakeholders, shall develop criteria designed
 156.28 to preserve access to nursing facility services in isolated areas, rebalance long-term care,
 156.29 and improve quality. To the extent practicable, the commissioner shall ensure an even
 156.30 distribution of designations across the state.

156.31 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities
 156.32 designated as critical access nursing facilities:

157.1 (1) partial rebasing, with the commissioner allowing a designated facility operating
 157.2 payment rates being the sum of up to 60 percent of the operating payment rate determined
 157.3 in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of
 157.4 the two portions being equal to 100 percent, of the operating payment rate that would have
 157.5 been allowed had the facility not been designated. The commissioner may adjust these
 157.6 percentages by up to 20 percent and may approve a request for less than the amount allowed;

157.7 (2) enhanced payments for leave days. Notwithstanding section 256R.43, upon
 157.8 designation as a critical access nursing facility, the commissioner shall limit payment for
 157.9 leave days to 60 percent of that nursing facility's total payment rate for the involved resident,
 157.10 and shall allow this payment only when the occupancy of the nursing facility, inclusive of
 157.11 bed hold days, is equal to or greater than 90 percent;

157.12 (3) two designated critical access nursing facilities, with up to 100 beds in active service,
 157.13 may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part
 157.14 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner
 157.15 of health shall consider each waiver request independently based on the criteria under
 157.16 Minnesota Rules, part 4658.0040;

157.17 (4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall
 157.18 be 40 percent of the amount that would otherwise apply; and

157.19 (5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to
 157.20 designated critical access nursing facilities.

157.21 (d) Designation of a critical access nursing facility is for a period of two years, after
 157.22 which the benefits allowed under paragraph (c) shall be removed. Designated facilities may
 157.23 apply for continued designation.

157.24 (e) This section is suspended and no state or federal funding shall be appropriated or
 157.25 allocated for the purposes of this section from January 1, 2016, to December 31, ~~2017~~ 2019.

157.26 **EFFECTIVE DATE.** This section is effective the day following final enactment.

157.27 Sec. 48. Minnesota Statutes 2016, section 256R.49, subdivision 1, is amended to read:

157.28 Subdivision 1. **Rate adjustments for compensation-related costs.** (a) ~~Operating payment~~
 157.29 ~~rates of all nursing facilities that are reimbursed under this chapter shall be increased effective~~
 157.30 ~~for rate years beginning on and after October 1, 2014, to address changes in compensation~~
 157.31 ~~costs for nursing facility employees paid less than \$14 per hour in accordance with this~~
 157.32 ~~section.~~ Rate increases provided under this section before October 1, 2016, expire effective

158.1 January 1, 2018, and rate increases provided on or after October 1, 2016, expire effective
 158.2 January 1, 2019.

158.3 (b) Nursing facilities that receive approval of the applications in subdivision 2 must
 158.4 receive rate adjustments according to subdivision 4. The rate adjustments must be used to
 158.5 pay compensation costs for nursing facility employees paid less than \$14 per hour.

158.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

158.7 Sec. 49. Minnesota Statutes 2016, section 256R.53, subdivision 2, is amended to read:

158.8 Subd. 2. **Nursing ~~facility~~ facilities in Breckenridge border cities.** The operating
 158.9 payment rate of a nonprofit nursing facility that exists on January 1, 2015, is located within
 158.10 the boundaries of the ~~city~~ cities of Breckenridge or Moorhead, and is reimbursed under this
 158.11 chapter, is equal to the greater of:

158.12 (1) the operating payment rate determined under section 256R.21, subdivision 3; or

158.13 (2) the median case mix adjusted rates, including comparable rate components as
 158.14 determined by the median case mix adjusted rates, including comparable rate components
 158.15 as determined by the commissioner, for the equivalent case mix indices of the nonprofit
 158.16 nursing facility or facilities located in an adjacent city in another state and in cities contiguous
 158.17 to the adjacent city. The commissioner shall make the comparison required in this subdivision
 158.18 on November 1 of each year and shall apply it to the rates to be effective on the following
 158.19 January 1. The Minnesota facility's operating payment rate with a case mix index of 1.0 is
 158.20 computed by dividing the adjacent city's nursing facility or facilities' median operating
 158.21 payment rate with an index of 1.02 by 1.02. If the adjustments under this subdivision result
 158.22 in a rate that exceeds the limits in section 256R.23, subdivision 5, and whose costs exceed
 158.23 the rate in section 256R.24, subdivision 3, in a given rate year, the facility's rate shall not
 158.24 be subject to the limits in section 256R.23, subdivision 5, and shall not be limited to the
 158.25 rate established in section 256R.24, subdivision 3, for that rate year.

158.26 **EFFECTIVE DATE.** The rate increases for a facility located in Moorhead are effective
 158.27 for the rate year beginning January 1, 2020, and annually thereafter.

158.28 Sec. 50. **DIRECTION TO COMMISSIONER; ADULT DAY SERVICES STAFFING**
 158.29 **RATIOS.**

158.30 The commissioner of human services shall study the staffing ratio for adult day services
 158.31 clients and shall provide the chairs and ranking minority members of the house of

159.1 representatives and senate committees with jurisdiction over adult day services with
159.2 recommendations to adjust staffing ratios based on client needs by January 1, 2018.

159.3 **Sec. 51. ALZHEIMER'S DISEASE WORKING GROUP.**

159.4 Subdivision 1. **Members.** (a) The Minnesota Board on Aging must appoint 16 members
159.5 to an Alzheimer's disease working group, as follows:

159.6 (1) a caregiver of a person who has been diagnosed with Alzheimer's disease;

159.7 (2) a person who has been diagnosed with Alzheimer's disease;

159.8 (3) two representatives from the nursing facility or senior housing profession;

159.9 (4) a representative of the home care or adult day services profession;

159.10 (5) two geriatricians, one of whom serves a diverse or underserved community;

159.11 (6) a psychologist who specializes in dementia care;

159.12 (7) an Alzheimer's researcher;

159.13 (8) a representative of the Alzheimer's Association;

159.14 (9) two members from community-based organizations serving one or more diverse or
159.15 underserved communities;

159.16 (10) the commissioner of human services or a designee;

159.17 (11) the commissioner of health or a designee;

159.18 (12) the ombudsman for long-term care or a designee; and

159.19 (13) one member of the Minnesota Board on Aging, selected by the board.

159.20 (b) The executive director of the Minnesota Board on Aging serves on the working group
159.21 as a nonvoting member.

159.22 (c) The appointing authorities under this subdivision must complete their appointments
159.23 no later than December 15, 2017.

159.24 (d) To the extent practicable, the membership of the working group must reflect the
159.25 diversity in Minnesota, and must include representatives from rural and metropolitan areas
159.26 and representatives of different ethnicities, races, genders, ages, cultural groups, and abilities.

159.27 Subd. 2. **Duties; recommendations.** The Alzheimer's disease working group must
159.28 review and revise the 2011 report, Preparing Minnesota for Alzheimer's: the Budgetary,

160.1 Social and Personal Impacts. The working group shall consider and make recommendations
160.2 and findings on the following issues as related to Alzheimer's disease or other dementias:

160.3 (1) analysis and assessment of public health and health care data to accurately determine
160.4 trends and disparities in cognitive decline;

160.5 (2) public awareness, knowledge, and attitudes, including knowledge gaps, stigma,
160.6 availability of information, and supportive community environments;

160.7 (3) risk reduction, including health education and health promotion on risk factors,
160.8 safety, and potentially avoidable hospitalizations;

160.9 (4) diagnosis and treatment, including early detection, access to diagnosis, quality of
160.10 dementia care, and cost of treatment;

160.11 (5) professional education and training, including geriatric education for licensed health
160.12 care professionals and dementia-specific training for direct care workers, first responders,
160.13 and other professionals in communities;

160.14 (6) residential services, including cost to families as well as regulation and licensing
160.15 gaps; and

160.16 (7) cultural competence and responsiveness to reduce health disparities and improve
160.17 access to high-quality dementia care.

160.18 Subd. 3. **Meetings.** The Board on Aging must convene the first meeting of the working
160.19 group no later than January 15, 2018. Before the first meeting, the Board on Aging must
160.20 designate one member to serve as chair. Meetings of the working group must be open to
160.21 the public, and to the extent practicable, technological means, such as Web casts, shall be
160.22 used to reach the greatest number of people throughout the state. The working group may
160.23 not meet more than five times.

160.24 Subd. 4. **Compensation.** Members of the working group serve without compensation,
160.25 but may be reimbursed for allowed actual and necessary expenses incurred in the performance
160.26 of the member's duties for the working group in the same manner and amount as authorized
160.27 by the commissioner's plan adopted under Minnesota Statutes, section 43A.18, subdivision
160.28 2.

160.29 Subd. 5. **Administrative support.** The Minnesota Board on Aging shall provide
160.30 administrative support and arrange meeting space for the working group.

160.31 Subd. 6. **Report.** The Board on Aging must submit a report providing the findings and
160.32 recommendations of the working group, including any draft legislation necessary to

161.1 implement the recommendations, to the governor and chairs and ranking minority members
161.2 of the legislative committees with jurisdiction over health care by January 15, 2019.

161.3 Subd. 7. **Expiration.** The working group expires June 30, 2019, or the day after the
161.4 working group submits the report required in subdivision 6, whichever is earlier.

161.5 **Sec. 52. ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM.**

161.6 Subdivision 1. **Documentation; establishment.** The commissioner of human services
161.7 shall establish implementation requirements and standards for an electronic service delivery
161.8 documentation system to comply with the 21st Century Cures Act, Public Law 114-255.

161.9 Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have
161.10 the meanings given them.

161.11 (b) "Electronic service delivery documentation" means the electronic documentation of
161.12 the:

161.13 (1) type of service performed;

161.14 (2) individual receiving the service;

161.15 (3) date of the service;

161.16 (4) location of the service delivery;

161.17 (5) individual providing the service; and

161.18 (6) time the service begins and ends.

161.19 (c) "Electronic service delivery documentation system" means a system that provides
161.20 electronic service delivery documentation that complies with the 21st Century Cures Act,
161.21 Public Law 114-255, and the requirements of subdivision 3.

161.22 (d) "Service" means one of the following:

161.23 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
161.24 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; or

161.25 (2) community first services and supports under Minnesota Statutes, section 256B.85.

161.26 Subd. 3. **Requirements.** (a) In developing implementation requirements for an electronic
161.27 service delivery documentation system, the commissioner shall consider electronic visit
161.28 verification systems and other electronic service delivery documentation methods. The
161.29 commissioner shall convene stakeholders that will be impacted by an electronic service
161.30 delivery system, including service providers and their representatives, service recipients

162.1 and their representatives, and, as appropriate, those with expertise in the development and
162.2 operation of an electronic service delivery documentation system, to ensure that the
162.3 requirements:

162.4 (1) are minimally administratively and financially burdensome to a provider;

162.5 (2) are minimally burdensome to the service recipient and the least disruptive to the
162.6 service recipient in receiving and maintaining allowed services;

162.7 (3) consider existing best practices and use of electronic service delivery documentation;

162.8 (4) are conducted according to all state and federal laws;

162.9 (5) are effective methods for preventing fraud when balanced against the requirements
162.10 of clauses (1) and (2); and

162.11 (6) are consistent with the Department of Human Services' policies related to covered
162.12 services, flexibility of service use, and quality assurance.

162.13 (b) The commissioner shall make training available to providers on the electronic service
162.14 delivery documentation system requirements.

162.15 (c) The commissioner shall establish baseline measurements related to preventing fraud
162.16 and establish measures to determine the effect of electronic service delivery documentation
162.17 requirements on program integrity.

162.18 Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,
162.19 2018, to the chairs and ranking minority members of the legislative committees with
162.20 jurisdiction over human services with recommendations, based on the requirements of
162.21 subdivision 3, to establish electronic service delivery documentation system requirements
162.22 and standards. The report shall identify:

162.23 (1) the essential elements necessary to operationalize a base-level electronic service
162.24 delivery documentation system to be implemented by January 1, 2019; and

162.25 (2) enhancements to the base-level electronic service delivery documentation system to
162.26 be implemented by January 1, 2019, or after, with projected operational costs and the costs
162.27 and benefits for system enhancements.

162.28 (b) The report must also identify current regulations on service providers that are either
162.29 inefficient, minimally effective, or will be unnecessary with the implementation of an
162.30 electronic service delivery documentation system.

162.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

163.1 Sec. 53. **DIRECTION TO COMMISSIONER; ICF/DD PAYMENT RATE STUDY.**

163.2 Within available appropriations, the commissioner of human services shall study the
 163.3 intermediate care facility for persons with developmental disabilities payment rates under
 163.4 Minnesota Statutes, sections 256B.5011 to 256B.5013, and make recommendations on the
 163.5 rate structure to the chairs and ranking minority members of the legislative committees with
 163.6 jurisdiction over human services policy and finance by January 15, 2018.

163.7 Sec. 54. **REVISOR'S INSTRUCTION.**

163.8 The revisor of statutes, in consultation with the House Research Department, Office of
 163.9 Senate Counsel, Research, and Fiscal Analysis, and Department of Human Services shall
 163.10 prepare legislation for the 2018 legislative session to recodify laws governing the elderly
 163.11 waiver program in Minnesota Statutes, chapter 256B.

163.12 **EFFECTIVE DATE.** This section is effective the day following final enactment.

163.13

ARTICLE 4

163.14

HEALTH CARE

163.15 Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision
 163.16 to read:

163.17 **Subd. 2a. Audits of Department of Human Services.** (a) To ensure continuous
 163.18 legislative oversight and accountability, the legislative auditor shall give high priority to
 163.19 auditing the programs, services, and benefits administered by the Department of Human
 163.20 Services. The audits shall determine whether the department offered programs and provided
 163.21 services and benefits only to eligible persons and organizations, and complied with applicable
 163.22 legal requirements.

163.23 (b) The legislative auditor shall, based on an assessment of risk and using professional
 163.24 standards to provide a statistically significant sample, no less than three times each year,
 163.25 test a representative sample of persons enrolled in a medical assistance program or
 163.26 MinnesotaCare to determine whether they are eligible to receive benefits under those
 163.27 programs. The legislative auditor shall report the results to the commissioner of human
 163.28 services and recommend corrective actions. The commissioner shall provide a response to
 163.29 the legislative auditor within 20 business days, including corrective actions to be taken to
 163.30 address any problems identified by the legislative auditor and anticipated completion dates.
 163.31 The legislative auditor shall monitor the commissioner's implementation of corrective actions
 163.32 and periodically report the results to the Legislative Audit Commission and the chairs and

164.1 ranking minority members of the legislative committees with jurisdiction over health and
164.2 human services policy and finance. The legislative auditor's reports to the commission and
164.3 the chairs and ranking minority members must include recommendations for any legislative
164.4 actions needed to ensure that medical assistance and MinnesotaCare benefits are provided
164.5 only to eligible persons.

164.6 Sec. 2. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision to
164.7 read:

164.8 Subd. 2b. **Audits of managed care organizations.** (a) The legislative auditor shall audit
164.9 each managed care organization that contracts with the commissioner of human services to
164.10 provide health care services under sections 256B.69, 256B.692, and 256L.12. The legislative
164.11 auditor shall design the audits to determine if a managed care organization used the public
164.12 money in compliance with federal and state laws, rules, and in accordance with provisions
164.13 in the managed care organization's contract with the commissioner of human services. The
164.14 legislative auditor shall determine the schedule and scope of the audit work and may contract
164.15 with vendors to assist with the audits. The managed care organization must cooperate with
164.16 the legislative auditor and must provide the legislative auditor with all data, documents, and
164.17 other information, regardless of classification, that the legislative auditor requests to conduct
164.18 an audit. The legislative auditor shall periodically report audit results and recommendations
164.19 to the Legislative Audit Commission and the chairs and ranking minority members of the
164.20 legislative committees with jurisdiction over health and human services policy and finance.

164.21 (b) For purposes of this subdivision, a "managed care organization" means a
164.22 demonstration provider as defined under section 256B.69, subdivision 2.

164.23 Sec. 3. Minnesota Statutes 2016, section 13.69, subdivision 1, is amended to read:

164.24 Subdivision 1. **Classifications.** (a) The following government data of the Department
164.25 of Public Safety are private data:

164.26 (1) medical data on driving instructors, licensed drivers, and applicants for parking
164.27 certificates and special license plates issued to physically disabled persons;

164.28 (2) other data on holders of a disability certificate under section 169.345, except that (i)
164.29 data that are not medical data may be released to law enforcement agencies, and (ii) data
164.30 necessary for enforcement of sections 169.345 and 169.346 may be released to parking
164.31 enforcement employees or parking enforcement agents of statutory or home rule charter
164.32 cities and towns;

165.1 (3) Social Security numbers in driver's license and motor vehicle registration records,
165.2 except that Social Security numbers must be provided to the Department of Revenue for
165.3 purposes of tax administration, the Department of Labor and Industry for purposes of
165.4 workers' compensation administration and enforcement, and the Department of Natural
165.5 Resources for purposes of license application administration, and except that the last four
165.6 digits of the Social Security number must be provided to the Department of Human Services
165.7 for purposes of recovery of Minnesota health care program benefits paid; and

165.8 (4) data on persons listed as standby or temporary custodians under section 171.07,
165.9 subdivision 11, except that the data must be released to:

165.10 (i) law enforcement agencies for the purpose of verifying that an individual is a designated
165.11 caregiver; or

165.12 (ii) law enforcement agencies who state that the license holder is unable to communicate
165.13 at that time and that the information is necessary for notifying the designated caregiver of
165.14 the need to care for a child of the license holder.

165.15 The department may release the Social Security number only as provided in clause (3)
165.16 and must not sell or otherwise provide individual Social Security numbers or lists of Social
165.17 Security numbers for any other purpose.

165.18 (b) The following government data of the Department of Public Safety are confidential
165.19 data: data concerning an individual's driving ability when that data is received from a member
165.20 of the individual's family.

165.21 **EFFECTIVE DATE.** This section is effective July 1, 2017.

165.22 Sec. 4. **[62J.815] HEALTH CARE PROVIDERS PRICE DISCLOSURES.**

165.23 (a) Each health care provider, as defined by section 62J.03, subdivision 8, except hospitals
165.24 and outpatient surgical centers subject to the requirements of section 62J.82, shall maintain
165.25 a list of the services or procedures that correspond with the 35 most frequent current
165.26 procedural terminology (CPT) codes, and a list of the ten most frequent CPT codes for
165.27 preventive services used by the provider for reimbursement purposes and the provider's
165.28 charge for each of these services or procedures that the provider would charge to patients
165.29 who are not covered by private or public health care coverage.

165.30 (b) This list must be updated annually and be readily available on site at no cost to the
165.31 public. The provider must also post this information on the provider's Web site or the health
165.32 care clinic's Web site where the provider practices.

166.1 Sec. 5. Minnesota Statutes 2016, section 256.9686, subdivision 8, is amended to read:

166.2 Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.
166.3 Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June
166.4 30.

166.5 **EFFECTIVE DATE.** This section is effective the day following final enactment.

166.6 Sec. 6. Minnesota Statutes 2016, section 256.969, subdivision 1, is amended to read:

166.7 Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in
166.8 the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The
166.9 commissioner shall use the indices as forecasted for the midpoint of the prior rate year to
166.10 the midpoint of the current rate year.

166.11 (b) Except as authorized under this section, for fiscal years beginning on or after July
166.12 1, 1993, the commissioner of human services shall not provide automatic annual inflation
166.13 adjustments for hospital payment rates under medical assistance.

166.14 **EFFECTIVE DATE.** This section is effective July 1, 2017.

166.15 Sec. 7. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

166.16 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
166.17 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
166.18 to the following:

166.19 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
166.20 methodology;

166.21 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
166.22 under subdivision 25;

166.23 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
166.24 distinct parts as defined by Medicare shall be paid according to the methodology under
166.25 subdivision 12; and

166.26 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

166.27 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
166.28 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
166.29 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
166.30 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
166.31 December 31, 2010. For rate setting periods after November 1, 2014, in which the base

167.1 years are updated, a Minnesota long-term hospital's base year shall remain within the same
167.2 period as other hospitals.

167.3 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
167.4 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
167.5 area, except for the hospitals paid under the methodologies described in paragraph (a),
167.6 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
167.7 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
167.8 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
167.9 that the total aggregate payments under the rebased system are equal to the total aggregate
167.10 payments that were made for the same number and types of services in the base year. Separate
167.11 budget neutrality calculations shall be determined for payments made to critical access
167.12 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases
167.13 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during
167.14 the entire base period shall be incorporated into the budget neutrality calculation.

167.15 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
167.16 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
167.17 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
167.18 a five percent increase or decrease from the base year payments for any hospital. Any
167.19 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
167.20 shall maintain budget neutrality as described in paragraph (c).

167.21 (e) For discharges occurring on or after November 1, 2014, through the next two rebasing
167.22 ~~that occurs~~ periods the commissioner may make additional adjustments to the rebased rates,
167.23 and when evaluating whether additional adjustments should be made, the commissioner
167.24 shall consider the impact of the rates on the following:

167.25 (1) pediatric services;

167.26 (2) behavioral health services;

167.27 (3) trauma services as defined by the National Uniform Billing Committee;

167.28 (4) transplant services;

167.29 (5) obstetric services, newborn services, and behavioral health services provided by
167.30 hospitals outside the seven-county metropolitan area;

167.31 (6) outlier admissions;

167.32 (7) low-volume providers; and

168.1 (8) services provided by small rural hospitals that are not critical access hospitals.

168.2 (f) Hospital payment rates established under paragraph (c) must incorporate the following:

168.3 (1) for hospitals paid under the DRG methodology, the base year payment rate per
168.4 admission is standardized by the applicable Medicare wage index and adjusted by the
168.5 hospital's disproportionate population adjustment;

168.6 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
168.7 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
168.8 October 31, 2014;

168.9 (3) the cost and charge data used to establish hospital payment rates must only reflect
168.10 inpatient services covered by medical assistance; and

168.11 (4) in determining hospital payment rates for discharges occurring on or after the rate
168.12 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
168.13 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
168.14 program in effect during the base year or years. In determining hospital payment rates for
168.15 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
168.16 methods and allowable costs of the Medicare program in effect during the base year or
168.17 years.

168.18 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
168.19 the rates established under paragraph (c), and any adjustments made to the rates under
168.20 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the
168.21 total aggregate payments for the same number and types of services under the rebased rates
168.22 are equal to the total aggregate payments made during calendar year 2013.

168.23 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
168.24 thereafter, payment rates under this section shall be rebased to reflect only those changes
168.25 in hospital costs between the existing base year and the next base year. Changes in costs
168.26 between base years shall be measured using the lower of the hospital cost index defined in
168.27 subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
168.28 claim. The commissioner shall establish the base year for each rebasing period considering
168.29 the most recent year for which filed Medicare cost reports are available. The estimated
168.30 change in the average payment per hospital discharge resulting from a scheduled rebasing
168.31 must be calculated and made available to the legislature by January 15 of each year in which
168.32 rebasing is scheduled to occur, and must include by hospital the differential in payment
168.33 rates compared to the individual hospital's costs.

169.1 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
169.2 for critical access hospitals located in Minnesota or the local trade area shall be determined
169.3 using a new cost-based methodology. The commissioner shall establish within the
169.4 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
169.5 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
169.6 the total cost for critical access hospitals as reflected in base year cost reports. Until the
169.7 next rebasing that occurs, the new methodology shall result in no greater than a five percent
169.8 decrease from the base year payments for any hospital, except a hospital that had payments
169.9 that were greater than 100 percent of the hospital's costs in the base year shall have their
169.10 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
169.11 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
169.12 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
169.13 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
169.14 following criteria:

169.15 (1) hospitals that had payments at or below 80 percent of their costs in the base year
169.16 shall have a rate set that equals 85 percent of their base year costs;

169.17 (2) hospitals that had payments that were above 80 percent, up to and including 90
169.18 percent of their costs in the base year shall have a rate set that equals 95 percent of their
169.19 base year costs; and

169.20 (3) hospitals that had payments that were above 90 percent of their costs in the base year
169.21 shall have a rate set that equals 100 percent of their base year costs.

169.22 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
169.23 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
169.24 methodology may include, but are not limited to:

169.25 (1) the ratio between the hospital's costs for treating medical assistance patients and the
169.26 hospital's charges to the medical assistance program;

169.27 (2) the ratio between the hospital's costs for treating medical assistance patients and the
169.28 hospital's payments received from the medical assistance program for the care of medical
169.29 assistance patients;

169.30 (3) the ratio between the hospital's charges to the medical assistance program and the
169.31 hospital's payments received from the medical assistance program for the care of medical
169.32 assistance patients;

169.33 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

170.1 (5) the proportion of that hospital's costs that are administrative and trends in
170.2 administrative costs; and
170.3 (6) geographic location.

170.4 **EFFECTIVE DATE.** This section is effective July 1, 2017.

170.5 Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 3a, is amended to read:

170.6 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program
170.7 must not be submitted until the recipient is discharged. However, the commissioner shall
170.8 establish monthly interim payments for inpatient hospitals that have individual patient
170.9 lengths of stay over 30 days regardless of diagnostic category. Except as provided in section
170.10 256.9693, medical assistance reimbursement for treatment of mental illness shall be
170.11 reimbursed based on diagnostic classifications. Individual hospital payments established
170.12 under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party
170.13 and recipient liability, for discharges occurring during the rate year shall not exceed, in
170.14 aggregate, the charges for the medical assistance covered inpatient services paid for the
170.15 same period of time to the hospital. Services that have rates established under subdivision
170.16 ~~11 or~~ 12, must be limited separately from other services. After consulting with the affected
170.17 hospitals, the commissioner may consider related hospitals one entity and may merge the
170.18 payment rates while maintaining separate provider numbers. The operating and property
170.19 base rates per admission or per day shall be derived from the best Medicare and claims data
170.20 available when rates are established. The commissioner shall determine the best Medicare
170.21 and claims data, taking into consideration variables of recency of the data, audit disposition,
170.22 settlement status, and the ability to set rates in a timely manner. The commissioner shall
170.23 notify hospitals of payment rates 30 days prior to implementation. The rate setting data
170.24 must reflect the admissions data used to establish relative values. The commissioner may
170.25 adjust base year cost, relative value, and case mix index data to exclude the costs of services
170.26 that have been discontinued by ~~the~~ October 1 of the year preceding the rate year or that are
170.27 paid separately from inpatient services. Inpatient stays that encompass portions of two or
170.28 more rate years shall have payments established based on payment rates in effect at the time
170.29 of admission unless the date of admission preceded the rate year in effect by six months or
170.30 more. In this case, operating payment rates for services rendered during the rate year in
170.31 effect and established based on the date of admission shall be adjusted to the rate year in
170.32 effect by the hospital cost index.

171.1 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment,
171.2 before third-party liability and spenddown, made to hospitals for inpatient services is reduced
171.3 by .5 percent from the current statutory rates.

171.4 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
171.5 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before
171.6 third-party liability and spenddown, is reduced five percent from the current statutory rates.
171.7 Mental health services within diagnosis related groups 424 to 432 or corresponding
171.8 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

171.9 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
171.10 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
171.11 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
171.12 the current statutory rates. Mental health services within diagnosis related groups 424 to
171.13 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded
171.14 from this paragraph. Payments made to managed care plans shall be reduced for services
171.15 provided on or after January 1, 2006, to reflect this reduction.

171.16 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
171.17 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
171.18 to hospitals for inpatient services before third-party liability and spenddown, is reduced
171.19 3.46 percent from the current statutory rates. Mental health services with diagnosis related
171.20 groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision
171.21 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced
171.22 for services provided on or after January 1, 2009, through June 30, 2009, to reflect this
171.23 reduction.

171.24 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
171.25 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
171.26 to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9
171.27 percent from the current statutory rates. Mental health services with diagnosis related groups
171.28 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are
171.29 excluded from this paragraph. Payments made to managed care plans shall be reduced for
171.30 services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

171.31 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
171.32 fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient
171.33 services before third-party liability and spenddown, is reduced 1.79 percent from the current
171.34 statutory rates. Mental health services with diagnosis related groups 424 to 432 or

172.1 corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from
172.2 this paragraph. Payments made to managed care plans shall be reduced for services provided
172.3 on or after July 1, 2011, to reflect this reduction.

172.4 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment
172.5 for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for
172.6 inpatient services before third-party liability and spenddown, is reduced one percent from
172.7 the current statutory rates. Facilities defined under subdivision 16 are excluded from this
172.8 paragraph. Payments made to managed care plans shall be reduced for services provided
172.9 on or after October 1, 2009, to reflect this reduction.

172.10 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment
172.11 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
172.12 inpatient services before third-party liability and spenddown, is reduced 1.96 percent from
172.13 the current statutory rates. Facilities defined under subdivision 16 are excluded from this
172.14 paragraph. Payments made to managed care plans shall be reduced for services provided
172.15 on or after January 1, 2011, to reflect this reduction.

172.16 (j) Effective for discharges on and after November 1, 2014, from hospitals paid under
172.17 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision
172.18 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),
172.19 and must not be applied to each claim.

172.20 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under
172.21 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
172.22 must be incorporated into the rates and must not be applied to each claim.

172.23 (l) Effective for discharges on and after July 1, 2017, from hospitals paid under
172.24 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be
172.25 incorporated into the rates and must not be applied to each claim.

172.26 **EFFECTIVE DATE.** This section is effective July 1, 2017.

172.27 Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 8, is amended to read:

172.28 Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day
172.29 outlier thresholds for each diagnostic category established under subdivision 2 at two standard
172.30 deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold
172.31 shall be in addition to the operating and property payment rates per admission established
172.32 under subdivisions 2 and 2b. Payment for outliers shall be at 70 percent of the allowable
172.33 operating cost, after adjustment by the case mix index, hospital cost index, relative values

173.1 and the disproportionate population adjustment. The outlier threshold for neonatal and burn
173.2 diagnostic categories shall be established at one standard deviation beyond the mean length
173.3 of stay, and payment shall be at 90 percent of allowable operating cost calculated in the
173.4 same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier
173.5 payment that is at a minimum of 60 percent and a maximum of 80 percent if the
173.6 commissioner is notified in writing of the request by October 1 of the year preceding the
173.7 rate year. The chosen percentage applies to all diagnostic categories except burns and
173.8 neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall
173.9 be added back to the base year operating payment rate per admission.

173.10 (b) Effective for admissions and transfers occurring on and after November 1, 2014, the
173.11 commissioner shall establish payment rates for outlier payments that are based on Medicare
173.12 methodologies.

173.13 **EFFECTIVE DATE.** This section is effective July 1, 2017.

173.14 Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 8c, is amended to read:

173.15 Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1,
173.16 2014, payments for hospital residents shall be made as follows:

173.17 (1) payments for the first 180 days of inpatient care shall be the APR-DRG system plus
173.18 any outliers; and

173.19 (2) payment for all medically necessary patient care subsequent to the first 180 days
173.20 shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge
173.21 ratio by the usual and customary charges.

173.22 (b) For discharges occurring on or after July 1, 2017, payment for hospital residents
173.23 shall be equal to the payments under subdivision 8, paragraph (b).

173.24 **EFFECTIVE DATE.** This section is effective July 1, 2017.

173.25 Sec. 11. Minnesota Statutes 2016, section 256.969, subdivision 9, is amended to read:

173.26 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions
173.27 occurring on or after July 1, 1993, the medical assistance disproportionate population
173.28 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional
173.29 treatment centers and facilities of the federal Indian Health Service, with a medical assistance
173.30 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined
173.31 as follows:

174.1 (1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic
174.2 mean for all hospitals excluding regional treatment centers and facilities of the federal Indian
174.3 Health Service but less than or equal to one standard deviation above the mean, the
174.4 adjustment must be determined by multiplying the total of the operating and property
174.5 payment rates by the difference between the hospital's actual medical assistance inpatient
174.6 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers
174.7 and facilities of the federal Indian Health Service; and

174.8 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
174.9 deviation above the mean, the adjustment must be determined by multiplying the adjustment
174.10 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
174.11 report annually on the number of hospitals likely to receive the adjustment authorized by
174.12 this paragraph. The commissioner shall specifically report on the adjustments received by
174.13 public hospitals and public hospital corporations located in cities of the first class.

174.14 (b) Certified public expenditures made by Hennepin County Medical Center shall be
174.15 considered Medicaid disproportionate share hospital payments. Hennepin County and
174.16 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning
174.17 July 1, 2005, or another date specified by the commissioner, that may qualify for
174.18 reimbursement under federal law. Based on these reports, the commissioner shall apply for
174.19 federal matching funds.

174.20 (c) Upon federal approval of the related state plan amendment, paragraph (b) is effective
174.21 retroactively from July 1, 2005, or the earliest effective date approved by the Centers for
174.22 Medicare and Medicaid Services.

174.23 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid
174.24 in accordance with a new methodology using 2012 as the base year. Annual payments made
174.25 under this paragraph shall equal the total amount of payments made for 2012. A licensed
174.26 children's hospital shall receive only a single DSH factor for children's hospitals. Other
174.27 DSH factors may be combined to arrive at a single factor for each hospital that is eligible
174.28 for DSH payments. The new methodology shall make payments only to hospitals located
174.29 in Minnesota and include the following factors:

174.30 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the
174.31 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000
174.32 fee-for-service discharges in the base year shall receive a factor of 0.7880;

175.1 (2) a hospital that has in effect for the initial rate year a contract with the commissioner
175.2 to provide extended psychiatric inpatient services under section 256.9693 shall receive a
175.3 factor of 0.0160;

175.4 (3) a hospital that has received payment from the fee-for-service program for at least 20
175.5 transplant services in the base year shall receive a factor of 0.0435;

175.6 (4) a hospital that has a medical assistance utilization rate in the base year between 20
175.7 percent up to one standard deviation above the statewide mean utilization rate shall receive
175.8 a factor of 0.0468;

175.9 (5) a hospital that has a medical assistance utilization rate in the base year that is at least
175.10 one standard deviation above the statewide mean utilization rate but is less than three standard
175.11 deviations above the mean shall receive a factor of 0.2300; and

175.12 (6) a hospital that has a medical assistance utilization rate in the base year that is at least
175.13 three standard deviations above the statewide mean utilization rate shall receive a factor of
175.14 0.3711.

175.15 (e) Any payments or portion of payments made to a hospital under this subdivision that
175.16 are subsequently returned to the commissioner because the payments are found to exceed
175.17 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the
175.18 number of fee-for-service discharges, to other DSH-eligible ~~non-children's~~ non-children's
175.19 hospitals that have a medical assistance utilization rate that is at least one standard deviation
175.20 above the mean.

175.21 **EFFECTIVE DATE.** This section is effective July 1, 2017.

175.22 Sec. 12. Minnesota Statutes 2016, section 256.969, subdivision 12, is amended to read:

175.23 Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) Units of hospitals that are
175.24 recognized as rehabilitation distinct parts by the Medicare program shall have separate
175.25 provider numbers under the medical assistance program for rate establishment and billing
175.26 purposes only. These units shall also have operating payment rates and the disproportionate
175.27 population adjustment, if allowed by federal law, established separately from other inpatient
175.28 hospital services.

175.29 (b) The commissioner shall establish separate relative values under subdivision 2 for
175.30 rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for
175.31 discharges occurring on and after November 1, 2014, the commissioner, to the extent
175.32 possible, shall replicate the existing payment rate methodology under the new diagnostic
175.33 classification system. The result must be budget neutral, ensuring that the total aggregate

176.1 payments under the new system are equal to the total aggregate payments made for the same
176.2 number and types of services in the base year, calendar year 2012.

176.3 (c) For individual hospitals that did not have separate medical assistance rehabilitation
176.4 provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the
176.5 information needed to separate rehabilitation distinct part cost and claims data from other
176.6 inpatient service data.

176.7 (d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals
176.8 shall be established under subdivision 2b, paragraph (a), clause (4).

176.9 **EFFECTIVE DATE.** This section is effective July 1, 2017.

176.10 Sec. 13. Minnesota Statutes 2016, section 256B.04, subdivision 12, is amended to read:

176.11 Subd. 12. **Limitation on services.** (a) Place limits on the types of services covered by
176.12 medical assistance, the frequency with which the same or similar services may be covered
176.13 by medical assistance for an individual recipient, and the amount paid for each covered
176.14 service. The state agency shall promulgate rules establishing maximum reimbursement rates
176.15 for emergency and nonemergency transportation.

176.16 The rules shall provide:

176.17 (1) an opportunity for all recognized transportation providers to be reimbursed for
176.18 nonemergency transportation consistent with the maximum rates established by the agency;
176.19 and

176.20 (2) reimbursement of public and private nonprofit providers serving the disabled
176.21 population generally at reasonable maximum rates that reflect the cost of providing the
176.22 service regardless of the fare that might be charged by the provider for similar services to
176.23 individuals other than those receiving medical assistance or medical care under this chapter;
176.24 and.

176.25 ~~(3) reimbursement for each additional passenger carried on a single trip at a substantially~~
176.26 ~~lower rate than the first passenger carried on that trip.~~

176.27 (b) The commissioner shall encourage providers reimbursed under this chapter to
176.28 coordinate their operation with similar services that are operating in the same community.
176.29 To the extent practicable, the commissioner shall encourage eligible individuals to utilize
176.30 less expensive providers capable of serving their needs.

176.31 (c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective
176.32 on January 1, 1981, "recognized provider of transportation services" means an operator of

177.1 special transportation service as defined in section 174.29 that has been issued a current
 177.2 certificate of compliance with operating standards of the commissioner of transportation
 177.3 or, if those standards do not apply to the operator, that the agency finds is able to provide
 177.4 the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized
 177.5 transportation provider" includes an operator of special transportation service that the agency
 177.6 finds is able to provide the required transportation in a safe and reliable manner.

177.7 Sec. 14. Minnesota Statutes 2016, section 256B.056, subdivision 5c, is amended to read:

177.8 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and
 177.9 caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard
 177.10 specified in subdivision 4, paragraph (b).

177.11 (b) The excess income standard for a person whose eligibility is based on blindness,
 177.12 disability, or age of 65 or more years shall equal ~~80~~ 81 percent of the federal poverty
 177.13 guidelines.

177.14 **EFFECTIVE DATE.** This section is effective June 1, 2019.

177.15 Sec. 15. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

177.16 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case
 177.17 management under this subdivision. Case managers may bill according to the following
 177.18 criteria:

177.19 (1) for relocation targeted case management, case managers may bill for direct case
 177.20 management activities, including face-to-face ~~and contact~~, telephone ~~contacts~~ contact, and
 177.21 interactive video contact according to section 256B.0924, subdivision 4a, in the lesser of:

177.22 (i) 180 days preceding an eligible recipient's discharge from an institution; or

177.23 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

177.24 (2) for home care targeted case management, case managers may bill for direct case
 177.25 management activities, including face-to-face and telephone contacts; and

177.26 (3) billings for targeted case management services under this subdivision shall not
 177.27 duplicate payments made under other program authorities for the same purpose.

177.28 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 177.29 of human services shall notify the revisor of statutes when federal approval is obtained.

- 178.1 Sec. 16. Minnesota Statutes 2016, section 256B.0625, subdivision 3b, is amended to read:
- 178.2 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
178.3 services and consultations delivered by a licensed health care provider via telemedicine in
178.4 the same manner as if the service or consultation was delivered in person. Coverage is
178.5 limited to three telemedicine services per enrollee per calendar week. Telemedicine services
178.6 shall be paid at the full allowable rate.
- 178.7 (b) The commissioner shall establish criteria that a health care provider must attest to
178.8 in order to demonstrate the safety or efficacy of delivering a particular service via
178.9 telemedicine. The attestation may include that the health care provider:
- 178.10 (1) has identified the categories or types of services the health care provider will provide
178.11 via telemedicine;
- 178.12 (2) has written policies and procedures specific to telemedicine services that are regularly
178.13 reviewed and updated;
- 178.14 (3) has policies and procedures that adequately address patient safety before, during,
178.15 and after the telemedicine service is rendered;
- 178.16 (4) has established protocols addressing how and when to discontinue telemedicine
178.17 services; and
- 178.18 (5) has an established quality assurance process related to telemedicine services.
- 178.19 (c) As a condition of payment, a licensed health care provider must document each
178.20 occurrence of a health service provided by telemedicine to a medical assistance enrollee.
178.21 Health care service records for services provided by telemedicine must meet the requirements
178.22 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:
- 178.23 (1) the type of service provided by telemedicine;
- 178.24 (2) the time the service began and the time the service ended, including an a.m. and p.m.
178.25 designation;
- 178.26 (3) the licensed health care provider's basis for determining that telemedicine is an
178.27 appropriate and effective means for delivering the service to the enrollee;
- 178.28 (4) the mode of transmission of the telemedicine service and records evidencing that a
178.29 particular mode of transmission was utilized;
- 178.30 (5) the location of the originating site and the distant site;

179.1 (6) if the claim for payment is based on a physician's telemedicine consultation with
 179.2 another physician, the written opinion from the consulting physician providing the
 179.3 telemedicine consultation; and

179.4 (7) compliance with the criteria attested to by the health care provider in accordance
 179.5 with paragraph (b).

179.6 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
 179.7 "telemedicine" is defined as the delivery of health care services or consultations while the
 179.8 patient is at an originating site and the licensed health care provider is at a distant site. A
 179.9 communication between licensed health care providers, or a licensed health care provider
 179.10 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
 179.11 does not constitute telemedicine consultations or services. Telemedicine may be provided
 179.12 by means of real-time two-way, interactive audio and visual communications, including the
 179.13 application of secure video conferencing or store-and-forward technology to provide or
 179.14 support health care delivery, which facilitate the assessment, diagnosis, consultation,
 179.15 treatment, education, and care management of a patient's health care.

179.16 (e) For purposes of this section, "licensed health care provider" ~~is defined~~ means a
 179.17 licensed health care provider under section 62A.671, subdivision 6, and a mental health
 179.18 practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26,
 179.19 working under the general supervision of a mental health professional; "health care provider"
 179.20 is defined under section 62A.671, subdivision 3; and "originating site" is defined under
 179.21 section 62A.671, subdivision 7.

179.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

179.23 Sec. 17. Minnesota Statutes 2016, section 256B.0625, subdivision 7, is amended to read:

179.24 Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in
 179.25 a recipient's home. Recipients who are authorized to receive home care nursing services in
 179.26 their home may use approved hours outside of the home during hours when normal life
 179.27 activities take them outside of their home. To use home care nursing services at school, the
 179.28 recipient or responsible party must provide written authorization in the care plan identifying
 179.29 the chosen provider and the daily amount of services to be used at school. Medical assistance
 179.30 does not cover home care nursing services for residents of a hospital, nursing facility,
 179.31 intermediate care facility, or a health care facility licensed by the commissioner of health,
 179.32 ~~except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or~~
 179.33 unless a resident who is otherwise eligible is on leave from the facility and the facility either
 179.34 pays for the home care nursing services or forgoes the facility per diem for the leave days

180.1 that home care nursing services are used. Total hours of service and payment allowed for
180.2 services outside the home cannot exceed that which is otherwise allowed in an in-home
180.3 setting according to sections 256B.0651 and 256B.0654 . All home care nursing services
180.4 must be provided according to the limits established under sections 256B.0651, 256B.0653,
180.5 and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family
180.6 foster care provider of a recipient who is under age 18, unless allowed under section
180.7 256B.0654, subdivision 4.

180.8 Sec. 18. Minnesota Statutes 2016, section 256B.0625, subdivision 13, is amended to read:

180.9 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when
180.10 specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed
180.11 by a licensed pharmacist, by a physician enrolled in the medical assistance program as a
180.12 dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed
180.13 by or under contract with a community health board as defined in section 145A.02,
180.14 subdivision 5, for the purposes of communicable disease control.

180.15 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
180.16 unless authorized by the commissioner.

180.17 (c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical
180.18 ingredient" is defined as a substance that is represented for use in a drug and when used in
180.19 the manufacturing, processing, or packaging of a drug becomes an active ingredient of the
180.20 drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle
180.21 for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and
180.22 excipients which are included in the medical assistance formulary. Medical assistance covers
180.23 selected active pharmaceutical ingredients and excipients used in compounded prescriptions
180.24 when the compounded combination is specifically approved by the commissioner or when
180.25 a commercially available product:

180.26 (1) is not a therapeutic option for the patient;

180.27 (2) does not exist in the same combination of active ingredients in the same strengths
180.28 as the compounded prescription; and

180.29 (3) cannot be used in place of the active pharmaceutical ingredient in the compounded
180.30 prescription.

180.31 (d) Medical assistance covers the following over-the-counter drugs when prescribed by
180.32 a licensed practitioner or by a licensed pharmacist who meets standards established by the
180.33 commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family

181.1 planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults
 181.2 with documented vitamin deficiencies, vitamins for children under the age of seven and
 181.3 pregnant or nursing women, and any other over-the-counter drug identified by the
 181.4 commissioner, in consultation with the formulary committee, as necessary, appropriate, and
 181.5 cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders,
 181.6 and this determination shall not be subject to the requirements of chapter 14. A pharmacist
 181.7 may prescribe over-the-counter medications as provided under this paragraph for purposes
 181.8 of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under
 181.9 this paragraph, licensed pharmacists must consult with the recipient to determine necessity,
 181.10 provide drug counseling, review drug therapy for potential adverse interactions, and make
 181.11 referrals as needed to other health care professionals. ~~Over-the-counter medications must~~
 181.12 ~~be dispensed in a quantity that is the lowest of: (1) the number of dosage units contained in~~
 181.13 ~~the manufacturer's original package; (2) the number of dosage units required to complete~~
 181.14 ~~the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed~~
 181.15 ~~from a system using retrospective billing, as provided under subdivision 13e, paragraph~~
 181.16 ~~(b).~~

181.17 (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable
 181.18 under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and
 181.19 Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible
 181.20 for drug coverage as defined in the Medicare Prescription Drug, Improvement, and
 181.21 Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these
 181.22 individuals, medical assistance may cover drugs from the drug classes listed in United States
 181.23 Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to
 181.24 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall
 181.25 not be covered.

181.26 (f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing
 181.27 Program and dispensed by 340B covered entities and ambulatory pharmacies under common
 181.28 ownership of the 340B covered entity. Medical assistance does not cover drugs acquired
 181.29 through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

181.30 Sec. 19. Minnesota Statutes 2016, section 256B.0625, subdivision 13e, is amended to
 181.31 read:

181.32 Subd. 13e. **Payment rates.** (a) Effective April 1, 2017, or upon federal approval,
 181.33 whichever is later, the basis for determining the amount of payment shall be the lower of
 181.34 the actual acquisition costs ingredient cost of the drugs ~~or the maximum allowable cost by~~

182.1 ~~the commissioner~~ plus the ~~fixed~~ professional dispensing fee; or the usual and customary
182.2 price charged to the public. The usual and customary price is defined as the lowest price
182.3 charged by the provider to a patient who pays for the prescription by cash, check, or charge
182.4 account and includes those prices the pharmacy charges to customers enrolled in a
182.5 prescription savings club or prescription discount club administered by the pharmacy or
182.6 pharmacy chain. The amount of payment basis must be reduced to reflect all discount
182.7 amounts applied to the charge by any third-party provider/insurer agreement or contract for
182.8 submitted charges to medical assistance programs. The net submitted charge may not be
182.9 greater than the patient liability for the service. The ~~pharmacy~~ professional dispensing fee
182.10 shall be ~~\$3.65~~ \$11.35 for ~~legend prescription drugs~~ prescriptions filled with legend drugs
182.11 meeting the definition of "covered outpatient drugs" according to United States Code, title
182.12 42, section 1396r-8(k)(2), except that the dispensing fee for intravenous solutions which
182.13 must be compounded by the pharmacist shall be \$8 \$11.35 ~~per bag, \$14 per bag for cancer~~
182.14 ~~chemotherapy products, and \$30 per bag for total parenteral nutritional products dispensed~~
182.15 ~~in one liter quantities, or \$44 per bag for total parenteral nutritional products dispensed in~~
182.16 ~~quantities greater than one liter.~~ The professional dispensing fee for prescriptions filled with
182.17 over-the-counter drugs meeting the definition of covered outpatient drugs shall be \$11.35
182.18 for dispensed quantities equal to or greater than the number of units contained in the
182.19 manufacturer's original package. The professional dispensing fee shall be prorated based
182.20 on the percentage of the package dispensed when the pharmacy dispenses a quantity less
182.21 than the number of units contained in the manufacturer's original package. The pharmacy
182.22 dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered
182.23 outpatient drugs shall be ~~\$3.65~~, ~~except that the fee shall be \$1.31 for retrospectively billing~~
182.24 ~~pharmacies when billing for quantities less than the number of units contained in the~~
182.25 ~~manufacturer's original package. Actual acquisition cost includes quantity and other special~~
182.26 ~~discounts except time and cash discounts. The actual acquisition~~ for quantities equal to or
182.27 greater than the number of units contained in the manufacturer's original package and shall
182.28 be prorated based on the percentage of the package dispensed when the pharmacy dispenses
182.29 a quantity less than the number of units contained in the manufacturer's original package.
182.30 The National Average Drug Acquisition Cost (NADAC) shall be used to determine the
182.31 ingredient cost of a drug ~~shall be estimated by the commissioner at wholesale acquisition~~
182.32 ~~cost plus four percent for independently owned pharmacies located in a designated rural~~
182.33 ~~area within Minnesota, and at wholesale acquisition cost plus two percent for all other~~
182.34 ~~pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies~~
182.35 ~~under the same ownership nationally. A "designated rural area" means an area defined as~~
182.36 ~~a small rural area or isolated rural area according to the four-category classification of the~~

183.1 ~~Rural Urban Commuting Area system developed for the United States Health Resources~~
183.2 ~~and Services Administration. Effective January 1, 2014, the actual acquisition. For drugs~~
183.3 ~~for which a NADAC is not reported, the commissioner shall estimate the ingredient cost at~~
183.4 ~~wholesale acquisition cost minus two percent. The commissioner shall establish the ingredient~~
183.5 ~~cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated~~
183.6 ~~by the commissioner at wholesale acquisition cost minus 40 percent at a 340B Drug Pricing~~
183.7 ~~Program maximum allowable cost. The 340B Drug Pricing Program maximum allowable~~
183.8 ~~cost shall be comparable to, but no higher than, the 340B Drug Pricing Program ceiling~~
183.9 ~~price established by the Health Resources and Services Administration. Wholesale acquisition~~
183.10 ~~cost is defined as the manufacturer's list price for a drug or biological to wholesalers or~~
183.11 ~~direct purchasers in the United States, not including prompt pay or other discounts, rebates,~~
183.12 ~~or reductions in price, for the most recent month for which information is available, as~~
183.13 ~~reported in wholesale price guides or other publications of drug or biological pricing data.~~
183.14 ~~The maximum allowable cost of a multisource drug may be set by the commissioner and it~~
183.15 ~~shall be comparable to, but the actual acquisition cost of the drug product and no higher~~
183.16 ~~than, the maximum amount paid by other third-party payors in this state who have maximum~~
183.17 ~~allowable cost programs and no higher than the NADAC of the generic product.~~
183.18 ~~Establishment of the amount of payment for drugs shall not be subject to the requirements~~
183.19 ~~of the Administrative Procedure Act.~~

183.20 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
183.21 an automated drug distribution system meeting the requirements of section 151.58, or a
183.22 packaging system meeting the packaging standards set forth in Minnesota Rules, part
183.23 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
183.24 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
183.25 retrospectively billing pharmacy must submit a claim only for the quantity of medication
183.26 used by the enrolled recipient during the defined billing period. A retrospectively billing
183.27 pharmacy must use a billing period not less than one calendar month or 30 days.

183.28 (c) ~~An additional dispensing fee of \$.30 may be added to the dispensing fee paid to~~
183.29 ~~pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities~~
183.30 ~~when a unit dose blister card system, approved by the department, is used. Under this type~~
183.31 ~~of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National~~
183.32 ~~Drug Code (NDC) from the drug container used to fill the blister card must be identified~~
183.33 ~~on the claim to the department. The unit dose blister card containing the drug must meet~~
183.34 ~~the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return~~
183.35 ~~of unused drugs to the pharmacy for reuse. A pharmacy provider using packaging that meets~~

184.1 the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the
184.2 department for the actual acquisition cost of all unused drugs that are eligible for reuse,
184.3 unless the pharmacy is using retrospective billing. The commissioner may permit the drug
184.4 clozapine to be dispensed in a quantity that is less than a 30-day supply.

184.5 (d) ~~Whenever a maximum allowable cost has been set for~~ If a pharmacy dispenses a
184.6 multisource drug, payment shall be the lower of the usual and customary price charged to
184.7 the public or the ingredient cost shall be the NADAC of the generic product or the maximum
184.8 allowable cost established by the commissioner unless prior authorization for the brand
184.9 name product has been granted according to the criteria established by the Drug Formulary
184.10 Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated
184.11 "dispense as written" on the prescription in a manner consistent with section 151.21,
184.12 subdivision 2.

184.13 (e) The basis for determining the amount of payment for drugs administered in an
184.14 outpatient setting shall be the lower of the usual and customary cost submitted by the
184.15 provider, 106 percent of the average sales price as determined by the United States
184.16 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
184.17 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
184.18 set by the commissioner. If average sales price is unavailable, the amount of payment must
184.19 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
184.20 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
184.21 Effective January 1, 2014, the commissioner shall discount the payment rate for drugs
184.22 obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for
184.23 drugs administered in an outpatient setting shall be made to the administering facility or
184.24 practitioner. A retail or specialty pharmacy dispensing a drug for administration in an
184.25 outpatient setting is not eligible for direct reimbursement.

184.26 (f) The commissioner may ~~negotiate lower reimbursement rates~~ establish maximum
184.27 allowable cost rates for specialty pharmacy products ~~than the rates that are lower than the~~
184.28 ingredient cost formulas specified in paragraph (a). The commissioner may require
184.29 individuals enrolled in the health care programs administered by the department to obtain
184.30 specialty pharmacy products from providers ~~with whom the commissioner has negotiated~~
184.31 lower reimbursement rates able to provide enhanced clinical services and willing to accept
184.32 the specialty pharmacy reimbursement. Specialty pharmacy products are defined as those
184.33 used by a small number of recipients or recipients with complex and chronic diseases that
184.34 require expensive and challenging drug regimens. Examples of these conditions include,
184.35 but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth

185.1 hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer.
185.2 Specialty pharmaceutical products include injectable and infusion therapies, biotechnology
185.3 drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex
185.4 care. The commissioner shall consult with the formulary committee to develop a list of
185.5 specialty pharmacy products subject to ~~this paragraph~~ maximum allowable cost
185.6 reimbursement. In consulting with the formulary committee in developing this list, the
185.7 commissioner shall take into consideration the population served by specialty pharmacy
185.8 products, the current delivery system and standard of care in the state, and access to care
185.9 issues. The commissioner shall have the discretion to adjust the ~~reimbursement rate~~ maximum
185.10 allowable cost to prevent access to care issues.

185.11 (g) Home infusion therapy services provided by home infusion therapy pharmacies must
185.12 be paid at rates according to subdivision 8d.

185.13 (h) Effective for prescriptions filled on or after April 1, 2017, or upon federal approval,
185.14 whichever is later, the commissioner shall increase the ingredient cost reimbursement
185.15 calculated in paragraphs (a) and (f) by two percent for prescription and nonprescription
185.16 drugs subject to the wholesale drug distributor tax under section 295.52.

185.17 **EFFECTIVE DATE.** This section is effective retroactively from April 1, 2017, or from
185.18 the effective date of federal approval, whichever is later. The commissioner of human
185.19 services shall notify the revisor of statutes when federal approval is obtained.

185.20 Sec. 20. Minnesota Statutes 2016, section 256B.0625, subdivision 17, is amended to read:

185.21 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
185.22 means motor vehicle transportation provided by a public or private person that serves
185.23 Minnesota health care program beneficiaries who do not require emergency ambulance
185.24 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

185.25 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
185.26 emergency medical care or transportation costs incurred by eligible persons in obtaining
185.27 emergency or nonemergency medical care when paid directly to an ambulance company,
185.28 ~~common carrier~~ nonemergency medical transportation company, or other recognized
185.29 providers of transportation services. Medical transportation must be provided by:

185.30 (1) nonemergency medical transportation providers who meet the requirements of this
185.31 subdivision;

185.32 (2) ambulances, as defined in section 144E.001, subdivision 2;

185.33 (3) taxicabs that meet the requirements of this subdivision;

186.1 (4) public transit, as defined in section 174.22, subdivision 7; or

186.2 (5) not-for-hire vehicles, including volunteer drivers.

186.3 (c) Medical assistance covers nonemergency medical transportation provided by
186.4 nonemergency medical transportation providers enrolled in the Minnesota health care
186.5 programs. All nonemergency medical transportation providers must comply with the
186.6 operating standards for special transportation service as defined in sections 174.29 to 174.30
186.7 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of
186.8 Transportation. All nonemergency medical transportation providers shall bill for
186.9 nonemergency medical transportation services in accordance with Minnesota health care
186.10 programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles
186.11 are exempt from the requirements outlined in this paragraph.

186.12 (d) An organization may be terminated, denied, or suspended from enrollment if:

186.13 (1) the provider has not initiated background studies on the individuals specified in
186.14 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

186.15 (2) the provider has initiated background studies on the individuals specified in section
186.16 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

186.17 (i) the commissioner has sent the provider a notice that the individual has been
186.18 disqualified under section 245C.14; and

186.19 (ii) the individual has not received a disqualification set-aside specific to the special
186.20 transportation services provider under sections 245C.22 and 245C.23.

186.21 (e) The administrative agency of nonemergency medical transportation must:

186.22 (1) adhere to the policies defined by the commissioner in consultation with the
186.23 Nonemergency Medical Transportation Advisory Committee;

186.24 (2) pay nonemergency medical transportation providers for services provided to
186.25 Minnesota health care programs beneficiaries to obtain covered medical services;

186.26 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
186.27 trips, and number of trips by mode; and

186.28 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single
186.29 administrative structure assessment tool that meets the technical requirements established
186.30 by the commissioner, reconciles trip information with claims being submitted by providers,
186.31 and ensures prompt payment for nonemergency medical transportation services.

187.1 (f) Until the commissioner implements the single administrative structure and delivery
187.2 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
187.3 commissioner or an entity approved by the commissioner that does not dispatch rides for
187.4 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

187.5 (g) The commissioner may use an order by the recipient's attending physician or a medical
187.6 or mental health professional to certify that the recipient requires nonemergency medical
187.7 transportation services. Nonemergency medical transportation providers shall perform
187.8 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
187.9 includes passenger pickup at and return to the individual's residence or place of business,
187.10 assistance with admittance of the individual to the medical facility, and assistance in
187.11 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

187.12 Nonemergency medical transportation providers must take clients to the health care
187.13 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
187.14 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
187.15 authorization from the local agency.

187.16 Nonemergency medical transportation providers may not bill for separate base rates for
187.17 the continuation of a trip beyond the original destination. Nonemergency medical
187.18 transportation providers must maintain trip logs, which include pickup and drop-off times,
187.19 signed by the medical provider or client, whichever is deemed most appropriate, attesting
187.20 to mileage traveled to obtain covered medical services. Clients requesting client mileage
187.21 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
187.22 services.

187.23 (h) The administrative agency shall use the level of service process established by the
187.24 commissioner in consultation with the Nonemergency Medical Transportation Advisory
187.25 Committee to determine the client's most appropriate mode of transportation. If public transit
187.26 or a certified transportation provider is not available to provide the appropriate service mode
187.27 for the client, the client may receive a onetime service upgrade.

187.28 (i) The covered modes of transportation, ~~which may not be implemented without a new~~
187.29 ~~rate structure~~, are:

187.30 (1) client reimbursement, which includes client mileage reimbursement provided to
187.31 clients who have their own transportation, or to family or an acquaintance who provides
187.32 transportation to the client;

187.33 (2) volunteer transport, which includes transportation by volunteers using their own
187.34 vehicle;

188.1 (3) unassisted transport, which includes transportation provided to a client by a taxicab
188.2 or public transit. If a taxicab or public transit is not available, the client can receive
188.3 transportation from another nonemergency medical transportation provider;

188.4 (4) assisted transport, which includes transport provided to clients who require assistance
188.5 by a nonemergency medical transportation provider;

188.6 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
188.7 dependent on a device and requires a nonemergency medical transportation provider with
188.8 a vehicle containing a lift or ramp;

188.9 (6) protected transport, which includes transport provided to a client who has received
188.10 a prescreening that has deemed other forms of transportation inappropriate and who requires
188.11 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
188.12 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
188.13 the vehicle driver; and (ii) who is certified as a protected transport provider; and

188.14 (7) stretcher transport, which includes transport for a client in a prone or supine position
188.15 and requires a nonemergency medical transportation provider with a vehicle that can transport
188.16 a client in a prone or supine position.

188.17 (j) The local agency shall be the single administrative agency and shall administer and
188.18 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
188.19 commissioner has developed, made available, and funded the Web-based single
188.20 administrative structure, assessment tool, and level of need assessment under subdivision
188.21 18e. The local agency's financial obligation is limited to funds provided by the state or
188.22 federal government.

188.23 (k) The commissioner shall:

188.24 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
188.25 verify that the mode and use of nonemergency medical transportation is appropriate;

188.26 (2) verify that the client is going to an approved medical appointment; and

188.27 (3) investigate all complaints and appeals.

188.28 (l) The administrative agency shall pay for the services provided in this subdivision and
188.29 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
188.30 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
188.31 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

189.1 (m) Payments for nonemergency medical transportation must be paid based on the client's
189.2 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
189.3 medical assistance reimbursement rates for nonemergency medical transportation services
189.4 that are payable by or on behalf of the commissioner for nonemergency medical
189.5 transportation services are:

189.6 (1) \$0.22 per mile for client reimbursement;

189.7 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
189.8 transport;

189.9 (3) equivalent to the standard fare for unassisted transport when provided by public
189.10 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
189.11 medical transportation provider;

189.12 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

189.13 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

189.14 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

189.15 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
189.16 an additional attendant if deemed medically necessary.

189.17 (n) The base rate for nonemergency medical transportation services in areas defined
189.18 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
189.19 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
189.20 services in areas defined under RUCA to be rural or super rural areas is:

189.21 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
189.22 rate in paragraph (m), clauses (1) to (7); and

189.23 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
189.24 rate in paragraph (m), clauses (1) to (7).

189.25 (o) For purposes of reimbursement rates for nonemergency medical transportation
189.26 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
189.27 shall determine whether the urban, rural, or super rural reimbursement rate applies.

189.28 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
189.29 a census-tract based classification system under which a geographical area is determined
189.30 to be urban, rural, or super rural.

190.1 (q) The commissioner, when determining reimbursement rates for nonemergency medical
190.2 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
190.3 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

190.4 Sec. 21. Minnesota Statutes 2016, section 256B.0625, subdivision 17b, is amended to
190.5 read:

190.6 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency
190.7 medical transportation providers must document each occurrence of a service provided to
190.8 a recipient according to this subdivision. Providers must maintain odometer and other records
190.9 sufficient to distinguish individual trips with specific vehicles and drivers. The documentation
190.10 may be collected and maintained using electronic systems or software or in paper form but
190.11 must be made available and produced upon request. Program funds paid for transportation
190.12 that is not documented according to this subdivision shall be recovered by the department.

190.13 (b) A nonemergency medical transportation provider must compile transportation records
190.14 that meet the following requirements:

190.15 (1) the record must be in English and must be legible according to the standard of a
190.16 reasonable person;

190.17 (2) the recipient's name must be on each page of the record; and

190.18 (3) each entry in the record must document:

190.19 (i) the date on which the entry is made;

190.20 (ii) the date or dates the service is provided;

190.21 (iii) the printed last name, first name, and middle initial of the driver;

190.22 (iv) the signature of the driver attesting to the following: "I certify that I have accurately
190.23 reported in this record the trip miles I actually drove and the dates and times I actually drove
190.24 them. I understand that misreporting the miles driven and hours worked is fraud for which
190.25 I could face criminal prosecution or civil proceedings.";

190.26 (v) the signature of the recipient or authorized party attesting to the following: "I certify
190.27 that I received the reported transportation service.", or the signature of the provider of
190.28 medical services certifying that the recipient was delivered to the provider;

190.29 (vi) the address, or the description if the address is not available, of both the origin and
190.30 destination, and the mileage for the most direct route from the origin to the destination;

190.31 (vii) the mode of transportation in which the service is provided;

- 191.1 (viii) the license plate number of the vehicle used to transport the recipient;
- 191.2 (ix) whether the service was ambulatory or nonambulatory ~~until the modes under~~
- 191.3 ~~subdivision 17 are implemented;~~
- 191.4 (x) the time of the pickup and the time of the drop-off with "a.m." and "p.m."
- 191.5 designations;
- 191.6 (xi) the name of the extra attendant when an extra attendant is used to provide special
- 191.7 transportation service; and
- 191.8 (xii) the electronic source documentation used to calculate driving directions and mileage.

191.9 Sec. 22. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision

191.10 to read:

191.11 Subd. 17c. **Nursing facility transports.** A Minnesota health care program enrollee

191.12 residing in, or being discharged from, a licensed nursing facility is exempt from a level of

191.13 need determination and is eligible for nonemergency medical transportation services until

191.14 the enrollee no longer resides in a licensed nursing facility, as provided in section 256B.04,

191.15 subdivision 14a.

191.16 Sec. 23. Minnesota Statutes 2016, section 256B.0625, subdivision 18h, is amended to

191.17 read:

191.18 Subd. 18h. **Managed care.** (a) The following subdivisions ~~do not~~ apply to managed

191.19 care plans and county-based purchasing plans:

191.20 (1) subdivision 17, paragraphs ~~(d) to (k)~~ (a), (b), (i), and (n);

191.21 (2) subdivision ~~18e~~ 18; and

191.22 (3) subdivision ~~18g~~ 18a.

191.23 (b) A nonemergency medical transportation provider must comply with the operating

191.24 standards for special transportation service specified in sections 174.29 to 174.30 and

191.25 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire

191.26 vehicles are exempt from the requirements in this paragraph.

191.27 Sec. 24. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

191.28 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the

191.29 state agency, medical assistance covers case management services to persons with serious

191.30 and persistent mental illness and children with severe emotional disturbance. Services

192.1 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
192.2 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
192.3 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

192.4 (b) Entities meeting program standards set out in rules governing family community
192.5 support services as defined in section 245.4871, subdivision 17, are eligible for medical
192.6 assistance reimbursement for case management services for children with severe emotional
192.7 disturbance when these services meet the program standards in Minnesota Rules, parts
192.8 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

192.9 (c) Medical assistance and MinnesotaCare payment for mental health case management
192.10 shall be made on a monthly basis. In order to receive payment for an eligible child, the
192.11 provider must document at least a face-to-face contact with the child, the child's parents, or
192.12 the child's legal representative. To receive payment for an eligible adult, the provider must
192.13 document:

192.14 (1) at least a face-to-face contact with the adult or the adult's legal representative or a
192.15 contact by interactive video that meets the requirements of subdivision 20b; or

192.16 (2) at least a telephone contact with the adult or the adult's legal representative and
192.17 document a face-to-face contact or a contact by interactive video that meets the requirements
192.18 of subdivision 20b with the adult or the adult's legal representative within the preceding
192.19 two months.

192.20 (d) Payment for mental health case management provided by county or state staff shall
192.21 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
192.22 (b), with separate rates calculated for child welfare and mental health, and within mental
192.23 health, separate rates for children and adults.

192.24 (e) Payment for mental health case management provided by Indian health services or
192.25 by agencies operated by Indian tribes may be made according to this section or other relevant
192.26 federally approved rate setting methodology.

192.27 (f) Payment for mental health case management provided by vendors who contract with
192.28 a county or Indian tribe shall be based on a monthly rate negotiated by the host county or
192.29 tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
192.30 service to other payers. If the service is provided by a team of contracted vendors, the county
192.31 or tribe may negotiate a team rate with a vendor who is a member of the team. The team
192.32 shall determine how to distribute the rate among its members. No reimbursement received
192.33 by contracted vendors shall be returned to the county or tribe, except to reimburse the county
192.34 or tribe for advance funding provided by the county or tribe to the vendor.

193.1 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
193.2 and county or state staff, the costs for county or state staff participation in the team shall be
193.3 included in the rate for county-provided services. In this case, the contracted vendor, the
193.4 tribal agency, and the county may each receive separate payment for services provided by
193.5 each entity in the same month. In order to prevent duplication of services, each entity must
193.6 document, in the recipient's file, the need for team case management and a description of
193.7 the roles of the team members.

193.8 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
193.9 mental health case management shall be provided by the recipient's county of responsibility,
193.10 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
193.11 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
193.12 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
193.13 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
193.14 the recipient's county of responsibility.

193.15 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
193.16 and MinnesotaCare include mental health case management. When the service is provided
193.17 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
193.18 share.

193.19 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
193.20 that does not meet the reporting or other requirements of this section. The county of
193.21 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
193.22 is responsible for any federal disallowances. The county or tribe may share this responsibility
193.23 with its contracted vendors.

193.24 (k) The commissioner shall set aside a portion of the federal funds earned for county
193.25 expenditures under this section to repay the special revenue maximization account under
193.26 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

193.27 (1) the costs of developing and implementing this section; and

193.28 (2) programming the information systems.

193.29 (l) Payments to counties and tribal agencies for case management expenditures under
193.30 this section shall only be made from federal earnings from services provided under this
193.31 section. When this service is paid by the state without a federal share through fee-for-service,
193.32 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
193.33 shall include the federal earnings, the state share, and the county share.

194.1 (m) Case management services under this subdivision do not include therapy, treatment,
194.2 legal, or outreach services.

194.3 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
194.4 and the recipient's institutional care is paid by medical assistance, payment for case
194.5 management services under this subdivision is limited to the lesser of:

194.6 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
194.7 than six months in a calendar year; or

194.8 (2) the limits and conditions which apply to federal Medicaid funding for this service.

194.9 (o) Payment for case management services under this subdivision shall not duplicate
194.10 payments made under other program authorities for the same purpose.

194.11 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
194.12 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
194.13 mental health targeted case management services must actively support identification of
194.14 community alternatives for the recipient and discharge planning.

194.15 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
194.16 of human services shall notify the revisor of statutes when federal approval is obtained.

194.17 Sec. 25. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
194.18 to read:

194.19 **Subd. 20b. Mental health targeted case management through interactive video.** (a)
194.20 Subject to federal approval, contact made for targeted case management by interactive video
194.21 shall be eligible for payment if:

194.22 (1) the person receiving targeted case management services is residing in:

194.23 (i) a hospital;

194.24 (ii) a nursing facility; or

194.25 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging
194.26 establishment or lodging establishment that provides supportive services or health supervision
194.27 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

194.28 (2) interactive video is in the best interests of the person and is deemed appropriate by
194.29 the person receiving targeted case management or the person's legal guardian, the case
194.30 management provider, and the provider operating the setting where the person is residing;

195.1 (3) the use of interactive video is approved as part of the person's written personal service
195.2 or case plan, taking into consideration the person's vulnerability and active personal
195.3 relationships; and

195.4 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
195.5 required face-to-face contact.

195.6 (b) The person receiving targeted case management or the person's legal guardian has
195.7 the right to choose and consent to the use of interactive video under this subdivision and
195.8 has the right to refuse the use of interactive video at any time.

195.9 (c) The commissioner shall establish criteria that a targeted case management provider
195.10 must attest to in order to demonstrate the safety or efficacy of delivering the service via
195.11 interactive video. The attestation may include that the case management provider has:

195.12 (1) written policies and procedures specific to interactive video services that are regularly
195.13 reviewed and updated;

195.14 (2) policies and procedures that adequately address client safety before, during, and after
195.15 the interactive video services are rendered;

195.16 (3) established protocols addressing how and when to discontinue interactive video
195.17 services; and

195.18 (4) established a quality assurance process related to interactive video services.

195.19 (d) As a condition of payment, the targeted case management provider must document
195.20 the following for each occurrence of targeted case management provided by interactive
195.21 video:

195.22 (1) the time the service began and the time the service ended, including an a.m. and p.m.
195.23 designation;

195.24 (2) the basis for determining that interactive video is an appropriate and effective means
195.25 for delivering the service to the person receiving case management services;

195.26 (3) the mode of transmission of the interactive video services and records evidencing
195.27 that a particular mode of transmission was utilized;

195.28 (4) the location of the originating site and the distant site; and

195.29 (5) compliance with the criteria attested to by the targeted case management provider
195.30 as provided in paragraph (c).

196.1 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
196.2 of human services shall notify the revisor of statutes when federal approval is obtained.

196.3 Sec. 26. Minnesota Statutes 2016, section 256B.0625, subdivision 30, is amended to read:

196.4 Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services,
196.5 federally qualified health center services, nonprofit community health clinic services, and
196.6 public health clinic services. Rural health clinic services and federally qualified health center
196.7 services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and
196.8 (C). Payment for rural health clinic and federally qualified health center services shall be
196.9 made according to applicable federal law and regulation.

196.10 (b) A federally qualified health center (FQHC) that is beginning initial operation shall
196.11 submit an estimate of budgeted costs and visits for the initial reporting period in the form
196.12 and detail required by the commissioner. ~~A federally qualified health center~~ An FQHC that
196.13 is already in operation shall submit an initial report using actual costs and visits for the
196.14 initial reporting period. Within 90 days of the end of its reporting period, ~~a federally qualified~~
196.15 ~~health center~~ an FQHC shall submit, in the form and detail required by the commissioner,
196.16 a report of its operations, including allowable costs actually incurred for the period and the
196.17 actual number of visits for services furnished during the period, and other information
196.18 required by the commissioner. ~~Federally qualified health centers~~ FQHCs that file Medicare
196.19 cost reports shall provide the commissioner with a copy of the most recent Medicare cost
196.20 report filed with the Medicare program intermediary for the reporting year which support
196.21 the costs claimed on their cost report to the state.

196.22 (c) In order to continue cost-based payment under the medical assistance program
196.23 according to paragraphs (a) and (b), ~~a federally qualified health center~~ an FQHC or rural
196.24 health clinic must apply for designation as an essential community provider within six
196.25 months of final adoption of rules by the Department of Health according to section 62Q.19,
196.26 subdivision 7. For those ~~federally qualified health centers~~ FQHCs and rural health clinics
196.27 that have applied for essential community provider status within the six-month time
196.28 prescribed, medical assistance payments will continue to be made according to paragraphs
196.29 (a) and (b) for the first three years after application. For ~~federally qualified health centers~~
196.30 FQHCs and rural health clinics that either do not apply within the time specified above or
196.31 who have had essential community provider status for three years, medical assistance
196.32 payments for health services provided by these entities shall be according to the same rates
196.33 and conditions applicable to the same service provided by health care providers that are not
196.34 ~~federally qualified health centers~~ FQHCs or rural health clinics.

197.1 (d) Effective July 1, 1999, the provisions of paragraph (c) requiring a ~~federally qualified~~
 197.2 ~~health center~~ an FQHC or a rural health clinic to make application for an essential community
 197.3 provider designation in order to have cost-based payments made according to paragraphs
 197.4 (a) and (b) no longer apply.

197.5 (e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall
 197.6 be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

197.7 (f) Effective January 1, 2001, through December 31, 2018, each ~~federally qualified~~
 197.8 ~~health center~~ FQHC and rural health clinic may elect to be paid either under the prospective
 197.9 payment system established in United States Code, title 42, section 1396a(aa), or under an
 197.10 alternative payment methodology consistent with the requirements of United States Code,
 197.11 title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services.
 197.12 The alternative payment methodology shall be 100 percent of cost as determined according
 197.13 to Medicare cost principles.

197.14 (g) Effective for services provided on or after January 1, 2019, all claims for payment
 197.15 of clinic services provided by FQHCs and rural health clinics shall be paid by the
 197.16 commissioner, according to an annual election by the FQHC or rural health clinic, under
 197.17 the current prospective payment system described in paragraph (f), the alternative payment
 197.18 methodology described in paragraph (f), or the alternative payment methodology described
 197.19 in paragraph (l).

197.20 ~~(g)~~ (h) For purposes of this section, "nonprofit community clinic" is a clinic that:

197.21 (1) has nonprofit status as specified in chapter 317A;

197.22 (2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

197.23 (3) is established to provide health services to low-income population groups, uninsured,
 197.24 high-risk and special needs populations, underserved and other special needs populations;

197.25 (4) employs professional staff at least one-half of which are familiar with the cultural
 197.26 background of their clients;

197.27 (5) charges for services on a sliding fee scale designed to provide assistance to
 197.28 low-income clients based on current poverty income guidelines and family size; and

197.29 (6) does not restrict access or services because of a client's financial limitations or public
 197.30 assistance status and provides no-cost care as needed.

197.31 ~~(h)~~ (i) Effective for services provided on or after January 1, 2015, all claims for payment
 197.32 of clinic services provided by ~~federally qualified health centers~~ FQHCs and rural health

198.1 clinics shall be paid by the commissioner. Effective for services provided on or after January
198.2 1, 2015, through July 1, 2017, the commissioner shall determine the most feasible method
198.3 for paying claims from the following options:

198.4 (1) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims
198.5 directly to the commissioner for payment, and the commissioner provides claims information
198.6 for recipients enrolled in a managed care or county-based purchasing plan to the plan, on
198.7 a regular basis; or

198.8 (2) ~~federally qualified health centers~~ FQHCs and rural health clinics submit claims for
198.9 recipients enrolled in a managed care or county-based purchasing plan to the plan, and those
198.10 claims are submitted by the plan to the commissioner for payment to the clinic.

198.11 Effective for services provided on or after January 1, 2019, FQHCs and rural health clinics
198.12 shall submit claims directly to the commissioner for payment and the commissioner shall
198.13 provide claims information for recipients enrolled in a managed care plan or county-based
198.14 purchasing plan to the plan on a regular basis to be determined by the commissioner.

198.15 ~~(j)~~ (j) For clinic services provided prior to January 1, 2015, the commissioner shall
198.16 calculate and pay monthly the proposed managed care supplemental payments to clinics,
198.17 and clinics shall conduct a timely review of the payment calculation data in order to finalize
198.18 all supplemental payments in accordance with federal law. Any issues arising from a clinic's
198.19 review must be reported to the commissioner by January 1, 2017. Upon final agreement
198.20 between the commissioner and a clinic on issues identified under this subdivision, and in
198.21 accordance with United States Code, title 42, section 1396a(bb), no supplemental payments
198.22 for managed care plan or county-based purchasing plan claims for services provided prior
198.23 to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are
198.24 unable to resolve issues under this subdivision, the parties shall submit the dispute to the
198.25 arbitration process under section 14.57.

198.26 ~~(k)~~ (k) The commissioner shall seek a federal waiver, authorized under section 1115 of
198.27 the Social Security Act, to obtain federal financial participation at the 100 percent federal
198.28 matching percentage available to facilities of the Indian Health Service or tribal organization
198.29 in accordance with section 1905(b) of the Social Security Act for expenditures made to
198.30 organizations dually certified under Title V of the Indian Health Care Improvement Act,
198.31 Public Law 94-437, and as a ~~federally qualified health center~~ FQHC under paragraph (a)
198.32 that provides services to American Indian and Alaskan Native individuals eligible for
198.33 services under this subdivision.

199.1 (1) Effective for services provided on or after January 1, 2019, all claims for payment
199.2 of clinic services provided by FQHCs and rural health clinics shall be paid by the
199.3 commissioner according to the current prospective payment system described in paragraph
199.4 (f), or an alternative payment methodology with the following requirements:

199.5 (1) each FQHC and rural health clinic must receive a single medical and a single dental
199.6 organization rate;

199.7 (2) the commissioner shall reimburse FQHCs and rural health clinics for allowable costs,
199.8 including direct patient care costs and patient-related support services, based upon Medicare
199.9 cost principles that apply at the time the alternative payment methodology is calculated;

199.10 (3) the 2019 payment rates for FQHCs and rural health clinics:

199.11 (i) must be determined using each FQHC's and rural health clinic's Medicare cost reports
199.12 from 2015 and 2016. A provider must submit the required cost reports to the commissioner
199.13 within six months of the second base year calendar or fiscal year end. Cost reports must be
199.14 submitted six months before the quarter in which the base rate will take effect;

199.15 (ii) must be according to current Medicare cost principles applicable to FQHCs and rural
199.16 health clinics at the time of the alternative payment rate calculation without the application
199.17 of productivity screens and upper payment limits or the Medicare prospective payment
199.18 system FQHC aggregate mean upper payment limit; and

199.19 (iii) must provide for a 60-day appeals process;

199.20 (4) the commissioner shall inflate the base year payment rate for FQHCs and rural health
199.21 clinics to the effective date by using the Bureau of Economic Analysis's personal consumption
199.22 expenditures medical care inflator;

199.23 (5) the commissioner shall establish a statewide trend inflator using 2015-2020 costs
199.24 replacing the use of the personal consumption expenditures medical care inflator with the
199.25 2023 rate calculation forward;

199.26 (6) FQHC and rural health clinic payment rates shall be rebased by the commissioner
199.27 every two years using the methodology described in clause (3), using the provider's Medicare
199.28 cost reports from the previous third and fourth years. In nonrebased years, the commissioner
199.29 shall adjust using the Medicare economic index until 2023 when the statewide trend inflator
199.30 is available;

199.31 (7) the commissioner shall increase payments by two percent according to Laws 2003,
199.32 First Special Session chapter 14, article 13C, section 2, subdivision 6. This is an add-on to
199.33 the rate and must not be included in the base rate calculation;

200.1 (8) for FQHCs and rural health clinics seeking a change of scope of services:

200.2 (i) the commissioner shall require FQHCs and rural health clinics to submit requests to
200.3 the commissioner, if the change of scope would result in the medical or dental payment rate
200.4 currently received by the FQHC or rural health clinic increasing or decreasing by at least
200.5 2-1/2 percent;

200.6 (ii) FQHCs and rural health clinics shall submit the request to the commissioner within
200.7 seven business days of submission of the scope change to the federal Health Resources
200.8 Services Administration;

200.9 (iii) the effective date of the payment change is the date the Health Resources Services
200.10 Administration approves the FQHC's or rural health clinic's change of scope request;

200.11 (iv) for change of scope requests that do not require Health Resources Services
200.12 Administration approval, FQHCs and rural health clinics shall submit the request to the
200.13 commissioner before implementing the change, and the effective date of the change is the
200.14 date the commissioner receives the request from the FQHC or rural health clinic; and

200.15 (v) the commissioner shall provide a response to the FQHC's or rural health clinic's
200.16 change of scope request within 45 days of submission and provide a final decision regarding
200.17 approval or disapproval within 120 days of submission. If more information is needed to
200.18 evaluate the request, this timeline may be waived by mutual agreement of the commissioner
200.19 and the FQHC or rural health clinic; and

200.20 (9) the commissioner shall establish a payment rate for new FQHC and rural health
200.21 clinic organizations, considering the following factors:

200.22 (i) a comparison of patient caseload of FQHCs and rural health clinics within a 60-mile
200.23 radius for organizations established outside the seven-county metropolitan area and within
200.24 a 30-mile radius for organizations within the seven-county metropolitan area; and

200.25 (ii) if a comparison is not feasible under item (i), the commissioner may use Medicare
200.26 cost reports or audited financial statements to establish the base rate.

200.27 Sec. 27. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
200.28 to read:

200.29 Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance
200.30 covers post-arrest community-based service coordination for an individual who:

200.31 (1) has been identified as having a mental illness or substance use disorder using a
200.32 screening tool approved by the commissioner;

201.1 (2) does not require the security of a public detention facility and is not considered an
201.2 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
201.3 435.1010;

201.4 (3) meets the eligibility requirements in section 256B.056; and

201.5 (4) has agreed to participate in post-arrest community-based service coordination through
201.6 a diversion contract in lieu of incarceration.

201.7 (b) Post-arrest community-based service coordination means navigating services to
201.8 address a client's mental health, chemical health, social, economic, and housing needs, or
201.9 any other activity targeted at reducing the incidence of jail utilization and connecting
201.10 individuals with existing covered services available to them, including, but not limited to,
201.11 targeted case management, waiver case management, or care coordination.

201.12 (c) Post-arrest community-based service coordination must be provided by individuals
201.13 who are qualified under one of the following criteria:

201.14 (1) a licensed mental health professional as defined in section 245.462, subdivision 18,
201.15 clauses (1) to (6);

201.16 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working
201.17 under the clinical supervision of a mental health professional; or

201.18 (3) a certified peer specialist under section 256B.0615, working under the clinical
201.19 supervision of a mental health professional.

201.20 (d) Reimbursement must be made in 15-minute increments and allowed for up to 60
201.21 days following the initial determination of eligibility.

201.22 (e) Providers of post-arrest community-based service coordination shall annually report
201.23 to the commissioner on the number of individuals served, and number of the
201.24 community-based services that were accessed by recipients. The commissioner shall ensure
201.25 that services and payments provided under post-arrest community-based service coordination
201.26 do not duplicate services or payments provided under section 256B.0625, subdivision 20,
201.27 256B.0753, 256B.0755, or 256B.0757.

201.28 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for
201.29 post-arrest community-based service coordination services shall be provided by the recipient's
201.30 county of residence, from sources other than federal funds or funds used to match other
201.31 federal funds.

202.1 **EFFECTIVE DATE.** This section is effective upon federal approval for services
202.2 provided on or after July 1, 2017. The commissioner of human services shall notify the
202.3 revisor of statutes when federal approval is obtained.

202.4 Sec. 28. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

202.5 Subd. 64. **Investigational drugs, biological products, and devices.** (a) Medical
202.6 assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do
202.7 not cover costs incidental to, associated with, or resulting from the use of investigational
202.8 drugs, biological products, or devices as defined in section 151.375.

202.9 (b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program
202.10 if all the following conditions are met:

202.11 (1) the use of stiripentol is determined to be medically necessary;

202.12 (2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether
202.13 an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating
202.14 partial epilepsy in infancy due to an SCN2A genetic mutation;

202.15 (3) all other available covered prescription medications that are medically necessary for
202.16 the enrollee have been tried without successful outcomes; and

202.17 (4) the United States Food and Drug Administration has approved the treating physician's
202.18 individual patient investigational new drug application (IND) for the use of stiripentol for
202.19 treatment.

202.20 This paragraph does not apply to MinnesotaCare coverage under chapter 256L.

202.21 Sec. 29. Minnesota Statutes 2016, section 256B.072, is amended to read:

202.22 **256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT**
202.23 **SYSTEM.**

202.24 Subdivision 1. **Performance measures.** (a) The commissioner of human services shall
202.25 establish a performance reporting system for health care providers who provide health care
202.26 services to public program recipients covered under chapters 256B, 256D, and 256L,
202.27 reporting separately for managed care and fee-for-service recipients.

202.28 (b) The measures used for the performance reporting system for medical groups shall
202.29 include measures of care for asthma, diabetes, hypertension, and coronary artery disease
202.30 and measures of preventive care services. The measures used for the performance reporting
202.31 system for inpatient hospitals shall include measures of care for acute myocardial infarction,

203.1 heart failure, and pneumonia, and measures of care and prevention of surgical infections.

203.2 In the case of a medical group, the measures used shall be consistent with measures published
203.3 by nonprofit Minnesota or national organizations that produce and disseminate health care
203.4 quality measures or evidence-based health care guidelines. In the case of inpatient hospital
203.5 measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis
203.6 Health to advise on the development of the performance measures to be used for hospital
203.7 reporting. To enable a consistent measurement process across the community, the
203.8 commissioner may use measures of care provided for patients in addition to those identified
203.9 in paragraph (a). The commissioner shall ensure collaboration with other health care reporting
203.10 organizations so that the measures described in this section are consistent with those reported
203.11 by those organizations and used by other purchasers in Minnesota.

203.12 (c) The commissioner may require providers to submit information in a required format
203.13 to a health care reporting organization or to cooperate with the information collection
203.14 procedures of that organization. The commissioner may collaborate with a reporting
203.15 organization to collect information reported and to prevent duplication of reporting.

203.16 (d) By October 1, 2007, and annually thereafter, the commissioner shall report through
203.17 a public Web site the results by medical groups and hospitals, where possible, of the measures
203.18 under this section, and shall compare the results by medical groups and hospitals for patients
203.19 enrolled in public programs to patients enrolled in private health plans. To achieve this
203.20 reporting, the commissioner may collaborate with a health care reporting organization that
203.21 operates a Web site suitable for this purpose.

203.22 (e) Performance measures must be stratified as provided under section 62U.02,
203.23 subdivision 1, paragraph (b), and risk-adjusted as specified in section 62U.02, subdivision
203.24 3, paragraph (b).

203.25 (f) Assessment of patient satisfaction with chronic pain management for the purpose of
203.26 determining compensation or quality incentive payments is prohibited. The commissioner
203.27 shall require managed care plans, county-based purchasing plans, and integrated health
203.28 partnerships to comply with this requirement as a condition of contract. This prohibition
203.29 does not apply to:

203.30 (1) assessing patient satisfaction with chronic pain management for the purpose of quality
203.31 improvement; and

203.32 (2) pain management as a part of a palliative care treatment plan to treat patients with
203.33 cancer or patients receiving hospice care.

204.1 Subd. 2. **Adjustment of quality metrics for special populations.** Notwithstanding
 204.2 subdivision 1, paragraph (b), by January 1, 2019, the commissioner shall consider and
 204.3 appropriately adjust quality metrics and benchmarks for providers who primarily serve
 204.4 socio-economically complex patient populations and request to be scored on additional
 204.5 measures in this subdivision. This requirement applies to all medical assistance and
 204.6 MinnesotaCare programs and enrollees, including persons enrolled in managed care and
 204.7 county-based purchasing plans or other managed care organizations, persons receiving care
 204.8 under fee-for-service, and persons receiving care under value-based purchasing arrangements,
 204.9 including but not limited to initiatives operating under sections 256B.0751, 256B.0753,
 204.10 256B.0755, 256B.0756, and 256B.0757.

204.11 Sec. 30. Minnesota Statutes 2016, section 256B.0755, subdivision 1, is amended to read:

204.12 Subdivision 1. **Implementation.** (a) The commissioner shall ~~develop and authorize~~
 204.13 continue a demonstration project established under this section to test alternative and
 204.14 innovative integrated health care delivery systems partnerships, including accountable care
 204.15 organizations that provide services to a specified patient population for an agreed-upon total
 204.16 cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a
 204.17 request for proposals for participation in the demonstration project in consultation with
 204.18 hospitals, primary care providers, health plans, and other key stakeholders.

204.19 (b) In developing the request for proposals, the commissioner shall:

204.20 (1) establish uniform statewide methods of forecasting utilization and cost of care for
 204.21 the appropriate Minnesota public program populations, to be used by the commissioner for
 204.22 the ~~health care delivery system~~ integrated health partnership projects;

204.23 (2) identify key indicators of quality, access, patient satisfaction, and other performance
 204.24 indicators that will be measured, in addition to indicators for measuring cost savings;

204.25 (3) allow maximum flexibility to encourage innovation and variation so that a variety
 204.26 of provider collaborations are able to become ~~health care delivery systems~~ integrated health
 204.27 partnerships, and may be customized for the special needs and barriers of patient populations
 204.28 experiencing health disparities due to social, economic, racial, or ethnic factors;

204.29 (4) encourage and authorize different levels and types of financial risk;

204.30 (5) encourage and authorize projects representing a wide variety of geographic locations,
 204.31 patient populations, provider relationships, and care coordination models;

204.32 (6) encourage projects that involve close partnerships between the ~~health care delivery~~
 204.33 ~~system~~ integrated health partnership and counties and nonprofit agencies that provide services

205.1 to patients enrolled with the ~~health care delivery system~~ integrated health partnership,
205.2 including social services, public health, mental health, community-based services, and
205.3 continuing care;

205.4 (7) encourage projects established by community hospitals, clinics, and other providers
205.5 in rural communities;

205.6 (8) identify required covered services for a total cost of care model or services considered
205.7 in whole or partially in an analysis of utilization for a risk/gain sharing model;

205.8 (9) establish a mechanism to monitor enrollment;

205.9 (10) establish quality standards for the ~~delivery system~~ integrated health partnership
205.10 demonstrations that are appropriate for the particular patient population to be served; and

205.11 (11) encourage participation of privately insured population so as to create sufficient
205.12 alignment in demonstration systems.

205.13 (c) To be eligible to participate in the ~~demonstration project~~ an integrated health
205.14 partnership, a health care delivery system must:

205.15 (1) provide required covered services and care coordination to recipients enrolled in the
205.16 ~~health care delivery system~~ integrated health partnership;

205.17 (2) establish a process to monitor enrollment and ensure the quality of care provided;

205.18 (3) in cooperation with counties and community social service agencies, coordinate the
205.19 delivery of health care services with existing social services programs;

205.20 (4) provide a system for advocacy and consumer protection; and

205.21 (5) adopt innovative and cost-effective methods of care delivery and coordination, which
205.22 may include the use of allied health professionals, telemedicine, patient educators, care
205.23 coordinators, and community health workers.

205.24 (d) ~~A health care delivery system~~ An integrated health partnership demonstration may
205.25 be formed by the following groups of providers of services and suppliers if they have
205.26 established a mechanism for shared governance:

205.27 (1) professionals in group practice arrangements;

205.28 (2) networks of individual practices of professionals;

205.29 (3) partnerships or joint venture arrangements between hospitals and health care
205.30 professionals;

205.31 (4) hospitals employing professionals; and

206.1 (5) other groups of providers of services and suppliers as the commissioner determines
206.2 appropriate.

206.3 A managed care plan or county-based purchasing plan may participate in this
206.4 demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

206.5 ~~A health care delivery system~~ An integrated health partnership may contract with a
206.6 managed care plan or a county-based purchasing plan to provide administrative services,
206.7 including the administration of a payment system using the payment methods established
206.8 by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

206.9 (e) The commissioner may require ~~a health care delivery system~~ an integrated health
206.10 partnership to enter into additional third-party contractual relationships for the assessment
206.11 of risk and purchase of stop loss insurance or another form of insurance risk management
206.12 related to the delivery of care described in paragraph (c).

206.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

206.14 Sec. 31. Minnesota Statutes 2016, section 256B.0755, subdivision 3, is amended to read:

206.15 Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships
206.16 must accept responsibility for the quality of care based on standards established under
206.17 subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services
206.18 provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability
206.19 standards must be appropriate to the particular population served.

206.20 (b) ~~A health care delivery system~~ An integrated health partnership may contract and
206.21 coordinate with providers and clinics for the delivery of services and shall contract with
206.22 community health clinics, federally qualified health centers, community mental health
206.23 centers or programs, county agencies, and rural clinics to the extent practicable.

206.24 (c) ~~A health care delivery system~~ An integrated health partnership must indicate how it
206.25 will coordinate with other services affecting its patients' health, quality of care, and cost of
206.26 care that are provided by other providers, county agencies, and other organizations in the
206.27 local service area. The ~~health care delivery system~~ integrated health partnership must indicate
206.28 how it will engage other providers, counties, and organizations, including county-based
206.29 purchasing plans, that provide services to patients of the ~~health care delivery system~~
206.30 integrated health partnership on issues related to local population health, including applicable
206.31 local needs, priorities, and public health goals. The ~~health care delivery system~~ integrated
206.32 health partnership must describe how local providers, counties, organizations, including

207.1 county-based purchasing plans, and other relevant purchasers were consulted in developing
207.2 the application to participate in the demonstration project.

207.3 Sec. 32. Minnesota Statutes 2016, section 256B.0755, subdivision 4, is amended to read:

207.4 Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery~~
207.5 ~~systems~~ integrated health partnerships, the commissioner shall establish a total cost of care
207.6 benchmark or a risk/gain sharing payment model to be paid for services provided to the
207.7 recipients enrolled in a ~~health care delivery system~~ an integrated health partnership.

207.8 (b) The payment system may include incentive payments to ~~health care delivery systems~~
207.9 integrated health partnerships that meet or exceed annual quality and performance targets
207.10 realized through the coordination of care.

207.11 (c) An amount equal to the savings realized to the general fund as a result of the
207.12 demonstration project shall be transferred each fiscal year to the health care access fund.

207.13 (d) The payment system shall include a population-based payment that supports care
207.14 coordination services for all enrollees served by the integrated health partnerships, and is
207.15 risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with
207.16 chronic conditions, limited English skills, cultural differences, are homeless, or experience
207.17 health disparities or other barriers to health care. The population-based payment shall be a
207.18 per member, per month payment paid at least on a quarterly basis. Integrated health
207.19 partnerships receiving this payment must continue to meet cost and quality metrics under
207.20 the program to maintain eligibility for the population-based payment. An integrated health
207.21 partnership is eligible to receive a payment under this paragraph even if the partnership is
207.22 not participating in a risk-based or gain-sharing payment model and regardless of the size
207.23 of the patient population served by the integrated health partnership. Any integrated health
207.24 partnership participant certified as a health care home under section 256B.0751 that agrees
207.25 to a payment method that includes population-based payments for care coordination is not
207.26 eligible to receive health care home payment or care coordination fee authorized under
207.27 section 62U.03 or 256B.0753, subdivision 1, or in-reach care coordination under section
207.28 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled
207.29 or attributed to the integrated health partnership under this demonstration.

207.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

208.1 Sec. 33. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision
208.2 to read:

208.3 Subd. 9. **Patient incentives.** The commissioner may authorize an integrated health
208.4 partnership to provide incentives for patients to:

208.5 (1) see a primary care provider for an initial health assessment;

208.6 (2) maintain a continuous relationship with the primary care provider; and

208.7 (3) participate in ongoing health improvement and coordination of care activities.

208.8 Sec. 34. [256B.0759] HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION
208.9 PROJECT.

208.10 Subdivision 1. **Implementation.** (a) The commissioner shall develop and implement a
208.11 demonstration project to test alternative and innovative health care delivery system payment
208.12 and care models that provide services to medical assistance and MinnesotaCare enrollees
208.13 for an agreed-upon, prospective per capita or total cost of care payment. The commissioner
208.14 shall implement this demonstration project in coordination with, and as an expansion of,
208.15 the demonstration project authorized under section 256B.0755.

208.16 (b) In developing the demonstration project, the commissioner shall:

208.17 (1) establish uniform statewide methods of forecasting utilization and cost of care for
208.18 the medical assistance and MinnesotaCare populations to be served under the health care
208.19 delivery system project;

208.20 (2) identify key indicators of quality, access, and patient satisfaction, and identify methods
208.21 to measure cost savings;

208.22 (3) allow maximum flexibility to encourage innovation and variation so that a variety
208.23 of provider collaborations are able to participate as health care delivery systems, and health
208.24 care delivery systems can be customized to address the special needs and barriers of patient
208.25 populations;

208.26 (4) authorize participation by health care delivery systems representing a variety of
208.27 geographic locations, patient populations, provider relationships, and care coordination
208.28 models;

208.29 (5) recognize the close partnerships between health care delivery systems and the counties
208.30 and nonprofit agencies that also provide services to patients enrolled in the health care
208.31 delivery system, including social services, public health, mental health, community-based
208.32 services, and continuing care;

209.1 (6) identify services to be included under a prospective per capita payment model, and
 209.2 project utilization and cost of these services under a total cost of care risk/gain sharing
 209.3 model;

209.4 (7) establish a mechanism to monitor enrollment in each health care delivery system;
 209.5 and

209.6 (8) establish quality standards for delivery systems that are appropriate for the specific
 209.7 patient populations served.

209.8 Subd. 2. Requirements for health care delivery systems. (a) To be eligible to participate
 209.9 in the demonstration project, a health care delivery system must:

209.10 (1) provide required services and care coordination to individuals enrolled in the health
 209.11 care delivery system;

209.12 (2) establish a process to monitor enrollment and ensure the quality of care provided;

209.13 (3) in cooperation with counties and community social service agencies, coordinate the
 209.14 delivery of health care services with existing social services programs;

209.15 (4) provide a system for advocacy and consumer protection; and

209.16 (5) adopt innovative and cost-effective methods of care delivery and coordination, which
 209.17 may include the use of allied health professionals, telemedicine and patient educators, care
 209.18 coordinators, community paramedics, and community health workers.

209.19 (b) A health care delivery system may be formed by the following types of health care
 209.20 providers, if they have established, as applicable, a mechanism for shared governance:

209.21 (1) health care providers in group practice arrangements;

209.22 (2) networks of health care providers in individual practice;

209.23 (3) partnerships or joint venture arrangements between hospitals and health care providers;

209.24 (4) hospitals employing or contracting with the necessary range of health care providers;

209.25 and

209.26 (5) other entities, as the commissioner determines appropriate.

209.27 (c) A health care delivery system must contract with a third-party administrator to provide
 209.28 administrative services, including the administration of the payment system established
 209.29 under the demonstration project. The third-party administrator must conduct an assessment
 209.30 of risk, and must purchase stop-loss insurance or another form of insurance risk management
 209.31 related to the delivery of care. The commissioner may waive the requirement for contracting

210.1 with a third-party administrator if the health care delivery system can demonstrate to the
210.2 commissioner that it can satisfactorily perform all of the duties assigned to the third-party
210.3 administrator.

210.4 Subd. 3. **Enrollment.** (a) Individuals eligible for medical assistance or MinnesotaCare
210.5 shall be eligible for enrollment in a health care delivery system. Individuals required to
210.6 enroll in the prepaid medical assistance program or prepaid MinnesotaCare may opt out of
210.7 receiving care from a managed care or county-based purchasing plan, and elect to receive
210.8 care through a health care delivery system established under this section.

210.9 (b) Eligible applicants and recipients may enroll in a health care delivery system if the
210.10 system serves the county in which the applicant or recipient resides. If more than one health
210.11 care delivery system serves a county, the applicant or recipient may choose among the
210.12 delivery systems. Enrollment in a specific health care delivery system shall be for a 12-month
210.13 period, except that enrollees who do not maintain eligibility for medical assistance or
210.14 MinnesotaCare shall be disenrolled, and enrollees experiencing a qualifying life event, as
210.15 specified by the commissioner, may change health care delivery systems, or opt out of
210.16 receiving coverage through a health care delivery system, within 60 days of the date of the
210.17 qualifying life event.

210.18 (c) The commissioner shall assign an applicant or recipient to a health care delivery
210.19 system if:

210.20 (1) the applicant or recipient is currently or has recently been attributed to the health
210.21 care delivery system as part of an integrated health partnership under section 256B.0755;
210.22 or

210.23 (2) no choice has been made by the applicant or recipient. In this case, the commissioner
210.24 shall enroll an applicant or recipient based on geographic criteria or based on the health
210.25 care providers from whom the applicant or recipient has received prior care.

210.26 Subd. 4. **Accountability.** (a) Health care delivery systems are responsible for the quality
210.27 of care based on standards established by the commissioner, and for enrollee cost of care
210.28 and utilization of services. The commissioner shall adjust accountability standards including
210.29 the quality, cost, and utilization of care to take into account the social, economic, or cultural
210.30 barriers experienced by the health care delivery system's patient population.

210.31 (b) A health care delivery system must contract with community health clinics, federally
210.32 qualified health centers, community mental health centers or programs, county agencies,
210.33 and rural health clinics to the extent practicable.

211.1 (c) A health care delivery system must indicate to the commissioner how it will coordinate
 211.2 its services with those delivered by other providers, county agencies, and other organizations
 211.3 in the local service area. The health care delivery system must indicate how it will engage
 211.4 other providers, counties, and organizations that provide services to patients of the health
 211.5 care delivery system on issues related to local population health, including applicable local
 211.6 needs, priorities, and public health goals. The health care delivery system must describe
 211.7 how local providers, counties, and organizations were consulted in developing the application
 211.8 submitted to the commissioner requiring participation in the demonstration project.

211.9 Subd. 5. **Payment system.** The commissioner shall develop a payment system for the
 211.10 health care delivery system project that includes prospective per capita payments, total cost
 211.11 of care benchmarks, and risk/gain sharing payment options. The payment system may
 211.12 include incentive payments to health care delivery systems that meet or exceed annual
 211.13 quality and performance targets through the coordination of care.

211.14 Subd. 6. **Federal waiver or approval.** The commissioner shall seek all federal waivers
 211.15 or approval necessary to implement the health care delivery system demonstration project.
 211.16 The commissioner shall notify the chairs and ranking minority members of the legislative
 211.17 committees with jurisdiction over health and human services policy and finance of any
 211.18 federal action related to the request for waivers and approval.

211.19 **EFFECTIVE DATE.** This section is effective January 1, 2018, or upon receipt of
 211.20 federal waivers or approval, whichever is later. The commissioner of human services shall
 211.21 notify the revisor of statutes when federal approval is obtained.

211.22 Sec. 35. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision
 211.23 to read:

211.24 Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal
 211.25 approval, contact made for targeted case management by interactive video shall be eligible
 211.26 for payment under subdivision 6 if:

211.27 (1) the person receiving targeted case management services is residing in:

211.28 (i) a hospital;

211.29 (ii) a nursing facility; or

211.30 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging
 211.31 establishment or lodging establishment that provides supportive services or health supervision
 211.32 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

212.1 (2) interactive video is in the best interests of the person and is deemed appropriate by
212.2 the person receiving targeted case management or the person's legal guardian, the case
212.3 management provider, and the provider operating the setting where the person is residing;

212.4 (3) the use of interactive video is approved as part of the person's written personal service
212.5 or case plan; and

212.6 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
212.7 required face-to-face contact.

212.8 (b) The person receiving targeted case management or the person's legal guardian has
212.9 the right to choose and consent to the use of interactive video under this subdivision and
212.10 has the right to refuse the use of interactive video at any time.

212.11 (c) The commissioner shall establish criteria that a targeted case management provider
212.12 must attest to in order to demonstrate the safety or efficacy of delivering the service via
212.13 interactive video. The attestation may include that the case management provider has:

212.14 (1) written policies and procedures specific to interactive video services that are regularly
212.15 reviewed and updated;

212.16 (2) policies and procedures that adequately address client safety before, during, and after
212.17 the interactive video services are rendered;

212.18 (3) established protocols addressing how and when to discontinue interactive video
212.19 services; and

212.20 (4) established a quality assurance process related to interactive video services.

212.21 (d) As a condition of payment, the targeted case management provider must document
212.22 the following for each occurrence of targeted case management provided by interactive
212.23 video:

212.24 (1) the time the service began and the time the service ended, including an a.m. and p.m.
212.25 designation;

212.26 (2) the basis for determining that interactive video is an appropriate and effective means
212.27 for delivering the service to the person receiving case management services;

212.28 (3) the mode of transmission of the interactive video services and records evidencing
212.29 that a particular mode of transmission was utilized;

212.30 (4) the location of the originating site and the distant site; and

213.1 (5) compliance with the criteria attested to by the targeted case management provider
 213.2 as provided in paragraph (c).

213.3 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
 213.4 of human services shall notify the revisor of statutes when federal approval is obtained.

213.5 Sec. 36. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

213.6 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
 213.7 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
 213.8 payment limit for nonstate government hospitals. The commissioner shall then determine
 213.9 the amount of a supplemental payment to Hennepin County Medical Center and Regions
 213.10 Hospital for these services that would increase medical assistance spending in this category
 213.11 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
 213.12 In making this determination, the commissioner shall allot the available increases between
 213.13 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
 213.14 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
 213.15 shall adjust this allotment as necessary based on federal approvals, the amount of
 213.16 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,
 213.17 in order to maximize the additional total payments. The commissioner shall inform Hennepin
 213.18 County and Ramsey County of the periodic intergovernmental transfers necessary to match
 213.19 federal Medicaid payments available under this subdivision in order to make supplementary
 213.20 medical assistance payments to Hennepin County Medical Center and Regions Hospital
 213.21 equal to an amount that when combined with existing medical assistance payments to
 213.22 nonstate governmental hospitals would increase total payments to hospitals in this category
 213.23 for outpatient services to the aggregate upper payment limit for all hospitals in this category
 213.24 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make
 213.25 supplementary payments to Hennepin County Medical Center and Regions Hospital.

213.26 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
 213.27 determine an upper payment limit for physicians and other billing professionals affiliated
 213.28 with Hennepin County Medical Center and with Regions Hospital. The upper payment limit
 213.29 shall be based on the average commercial rate or be determined using another method
 213.30 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall
 213.31 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers
 213.32 necessary to match the federal Medicaid payments available under this subdivision in order
 213.33 to make supplementary payments to physicians and other billing professionals affiliated
 213.34 with Hennepin County Medical Center and to make supplementary payments to physicians

214.1 and other billing professionals affiliated with Regions Hospital through HealthPartners
 214.2 Medical Group equal to the difference between the established medical assistance payment
 214.3 for physician and other billing professional services and the upper payment limit. Upon
 214.4 receipt of these periodic transfers, the commissioner shall make supplementary payments
 214.5 to physicians and other billing professionals affiliated with Hennepin County Medical Center
 214.6 and shall make supplementary payments to physicians and other billing professionals
 214.7 affiliated with Regions Hospital through HealthPartners Medical Group.

214.8 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly
 214.9 voluntary intergovernmental transfers to the commissioner in amounts not to exceed
 214.10 \$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.
 214.11 The commissioner shall increase the medical assistance capitation payments to any licensed
 214.12 health plan under contract with the medical assistance program that agrees to make enhanced
 214.13 payments to Hennepin County Medical Center or Regions Hospital. The increase shall be
 214.14 in an amount equal to the annual value of the monthly transfers plus federal financial
 214.15 participation, with each health plan receiving its pro rata share of the increase based on the
 214.16 pro rata share of medical assistance admissions to Hennepin County Medical Center and
 214.17 Regions Hospital by those plans. Upon the request of the commissioner, health plans shall
 214.18 submit individual-level cost data for verification purposes. The commissioner may ratably
 214.19 reduce these payments on a pro rata basis in order to satisfy federal requirements for actuarial
 214.20 soundness. If payments are reduced, transfers shall be reduced accordingly. Any licensed
 214.21 health plan that receives increased medical assistance capitation payments under the
 214.22 intergovernmental transfer described in this paragraph shall increase its medical assistance
 214.23 payments to Hennepin County Medical Center and Regions Hospital by the same amount
 214.24 as the increased payments received in the capitation payment described in this paragraph.

214.25 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall
 214.26 determine an upper payment limit for ambulance services affiliated with Hennepin County
 214.27 Medical Center and the city of St. Paul, and ambulance services owned and operated by
 214.28 another governmental entity that chooses to participate by requesting the commissioner to
 214.29 determine an upper payment limit. The upper payment limit shall be based on the average
 214.30 commercial rate or be determined using another method acceptable to the Centers for
 214.31 Medicare and Medicaid Services. The commissioner shall inform Hennepin County ~~and,~~
 214.32 the city of St. Paul, and other participating governmental entities of the periodic
 214.33 intergovernmental transfers necessary to match the federal Medicaid payments available
 214.34 under this subdivision in order to make supplementary payments to Hennepin County
 214.35 Medical Center ~~and,~~ the city of St. Paul, and other participating governmental entities equal

215.1 to the difference between the established medical assistance payment for ambulance services
 215.2 and the upper payment limit. Upon receipt of these periodic transfers, the commissioner
 215.3 shall make supplementary payments to Hennepin County Medical Center ~~and~~ the city of
 215.4 St. Paul, and other participating governmental entities. A tribal government that owns and
 215.5 operates an ambulance service is not eligible to participate under this subdivision.

215.6 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall
 215.7 determine an upper payment limit for physicians, dentists, and other billing professionals
 215.8 affiliated with the University of Minnesota and University of Minnesota Physicians. The
 215.9 upper payment limit shall be based on the average commercial rate or be determined using
 215.10 another method acceptable to the Centers for Medicare and Medicaid Services. The
 215.11 commissioner shall inform the University of Minnesota Medical School and University of
 215.12 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to
 215.13 match the federal Medicaid payments available under this subdivision in order to make
 215.14 supplementary payments to physicians, dentists, and other billing professionals affiliated
 215.15 with the University of Minnesota and the University of Minnesota Physicians equal to the
 215.16 difference between the established medical assistance payment for physician, dentist, and
 215.17 other billing professional services and the upper payment limit. Upon receipt of these periodic
 215.18 transfers, the commissioner shall make supplementary payments to physicians, dentists,
 215.19 and other billing professionals affiliated with the University of Minnesota and the University
 215.20 of Minnesota Physicians.

215.21 (f) The commissioner shall inform the transferring governmental entities on an ongoing
 215.22 basis of the need for any changes needed in the intergovernmental transfers in order to
 215.23 continue the payments under paragraphs (a) to ~~(d)~~ (e), at their maximum level, including
 215.24 increases in upper payment limits, changes in the federal Medicaid match, and other factors.

215.25 ~~(f)~~ (g) The payments in paragraphs (a) to ~~(d)~~ (e) shall be implemented independently of
 215.26 each other, subject to federal approval and to the receipt of transfers under subdivision 3.

215.27 (h) All of the data and funding transactions related to the payments in paragraphs (a) to
 215.28 (e) shall be between the commissioner and the governmental entities.

215.29 (i) For purposes of this subdivision, billing professionals are limited to physicians, nurse
 215.30 practitioners, nurse midwives, clinical nurse specialists, physician assistants,
 215.31 anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and
 215.32 dental therapists.

216.1 **EFFECTIVE DATE.** Paragraph (d) is effective July 1, 2017, or upon federal approval,
216.2 whichever is later. The commissioner of human services shall notify the revisor of statutes
216.3 when federal approval is received.

216.4 Sec. 37. Minnesota Statutes 2016, section 256B.196, subdivision 3, is amended to read:

216.5 Subd. 3. **Intergovernmental transfers.** Based on the determination by the commissioner
216.6 under subdivision 2, Hennepin County and Ramsey County shall make periodic
216.7 intergovernmental transfers to the commissioner for the purposes of subdivision 2, paragraphs
216.8 (a) and (b). All of the intergovernmental transfers made by Hennepin County shall be used
216.9 to match federal payments to Hennepin County Medical Center under subdivision 2,
216.10 paragraph (a), and to physicians and other billing professionals affiliated with Hennepin
216.11 County Medical Center under subdivision 2, paragraph (b). All of the intergovernmental
216.12 transfers made by Ramsey County shall be used to match federal payments to Regions
216.13 Hospital under subdivision 2, paragraph (a), and to physicians and other billing professionals
216.14 affiliated with Regions Hospital through HealthPartners Medical Group under subdivision
216.15 2, paragraph (b). All of the intergovernmental transfer payments made by the University of
216.16 Minnesota Medical School and the University of Minnesota School of Dentistry shall be
216.17 used to match federal payments to the University of Minnesota and the University of
216.18 Minnesota Physicians under subdivision 2, paragraph (e).

216.19 Sec. 38. Minnesota Statutes 2016, section 256B.196, subdivision 4, is amended to read:

216.20 Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the
216.21 intergovernmental transfers under subdivision 3 and the payments under subdivision 2,
216.22 based on the commissioner's determination of Medicare upper payment limits,
216.23 hospital-specific charge limits, hospital-specific limitations on disproportionate share
216.24 payments, medical inflation, actuarial certification, average commercial rates for physician
216.25 and other professional services as defined in this section, and cost-effectiveness for purposes
216.26 of federal waivers. Any adjustments must be made on a proportional basis. The commissioner
216.27 may make adjustments under this subdivision only after consultation with the affected
216.28 counties, university schools, and hospitals. All payments under subdivision 2 and all
216.29 intergovernmental transfers under subdivision 3 are limited to amounts available after all
216.30 other base rates, adjustments, and supplemental payments in chapter 256B are calculated.

216.31 (b) The ratio of medical assistance payments specified in subdivision 2 to the voluntary
216.32 intergovernmental transfers specified in subdivision 3 shall not be reduced except as provided
216.33 under paragraph (a).

217.1 Sec. 39. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:

217.2 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and
217.3 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner
217.4 may issue separate contracts with requirements specific to services to medical assistance
217.5 recipients age 65 and older.

217.6 (b) A prepaid health plan providing covered health services for eligible persons pursuant
217.7 to chapters 256B and 256L is responsible for complying with the terms of its contract with
217.8 the commissioner. Requirements applicable to managed care programs under chapters 256B
217.9 and 256L established after the effective date of a contract with the commissioner take effect
217.10 when the contract is next issued or renewed.

217.11 (c) The commissioner shall withhold five percent of managed care plan payments under
217.12 this section and county-based purchasing plan payments under section 256B.692 for the
217.13 prepaid medical assistance program pending completion of performance targets. Each
217.14 performance target must be quantifiable, objective, measurable, and reasonably attainable,
217.15 except in the case of a performance target based on a federal or state law or rule. Criteria
217.16 for assessment of each performance target must be outlined in writing prior to the contract
217.17 effective date. Clinical or utilization performance targets and their related criteria must
217.18 consider evidence-based research and reasonable interventions when available or applicable
217.19 to the populations served, and must be developed with input from external clinical experts
217.20 and stakeholders, including managed care plans, county-based purchasing plans, and
217.21 providers. The managed care or county-based purchasing plan must demonstrate, to the
217.22 commissioner's satisfaction, that the data submitted regarding attainment of the performance
217.23 target is accurate. The commissioner shall periodically change the administrative measures
217.24 used as performance targets in order to improve plan performance across a broader range
217.25 of administrative services. The performance targets must include measurement of plan
217.26 efforts to contain spending on health care services and administrative activities. The
217.27 commissioner may adopt plan-specific performance targets that take into account factors
217.28 affecting only one plan, including characteristics of the plan's enrollee population. The
217.29 withheld funds must be returned no sooner than July of the following year if performance
217.30 targets in the contract are achieved. The commissioner may exclude special demonstration
217.31 projects under subdivision 23.

217.32 (d) The commissioner shall require that managed care plans use the assessment and
217.33 authorization processes, forms, timelines, standards, documentation, and data reporting
217.34 requirements, protocols, billing processes, and policies consistent with medical assistance
217.35 fee-for-service or the Department of Human Services contract requirements consistent with

218.1 medical assistance fee-for-service or the Department of Human Services contract
218.2 requirements for all personal care assistance services under section 256B.0659.

218.3 (e) Effective for services rendered on or after January 1, 2012, the commissioner shall
218.4 include as part of the performance targets described in paragraph (c) a reduction in the health
218.5 plan's emergency department utilization rate for medical assistance and MinnesotaCare
218.6 enrollees, as determined by the commissioner. For 2012, the reduction shall be based on
218.7 the health plan's utilization in 2009. To earn the return of the withhold each subsequent
218.8 year, the managed care plan or county-based purchasing plan must achieve a qualifying
218.9 reduction of no less than ten percent of the plan's emergency department utilization rate for
218.10 medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described
218.11 in subdivisions 23 and 28, compared to the previous measurement year until the final
218.12 performance target is reached. When measuring performance, the commissioner must
218.13 consider the difference in health risk in a managed care or county-based purchasing plan's
218.14 membership in the baseline year compared to the measurement year, and work with the
218.15 managed care or county-based purchasing plan to account for differences that they agree
218.16 are significant.

218.17 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
218.18 the following calendar year if the managed care plan or county-based purchasing plan
218.19 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
218.20 was achieved. The commissioner shall structure the withhold so that the commissioner
218.21 returns a portion of the withheld funds in amounts commensurate with achieved reductions
218.22 in utilization less than the targeted amount.

218.23 The withhold described in this paragraph shall continue for each consecutive contract
218.24 period until the plan's emergency room utilization rate for state health care program enrollees
218.25 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
218.26 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
218.27 health plans in meeting this performance target and shall accept payment withholds that
218.28 may be returned to the hospitals if the performance target is achieved.

218.29 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
218.30 include as part of the performance targets described in paragraph (c) a reduction in the plan's
218.31 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
218.32 determined by the commissioner. To earn the return of the withhold each year, the managed
218.33 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
218.34 than five percent of the plan's hospital admission rate for medical assistance and
218.35 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and

219.1 28, compared to the previous calendar year until the final performance target is reached.
219.2 When measuring performance, the commissioner must consider the difference in health risk
219.3 in a managed care or county-based purchasing plan's membership in the baseline year
219.4 compared to the measurement year, and work with the managed care or county-based
219.5 purchasing plan to account for differences that they agree are significant.

219.6 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
219.7 the following calendar year if the managed care plan or county-based purchasing plan
219.8 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
219.9 rate was achieved. The commissioner shall structure the withhold so that the commissioner
219.10 returns a portion of the withheld funds in amounts commensurate with achieved reductions
219.11 in utilization less than the targeted amount.

219.12 The withhold described in this paragraph shall continue until there is a 25 percent
219.13 reduction in the hospital admission rate compared to the hospital admission rates in calendar
219.14 year 2011, as determined by the commissioner. The hospital admissions in this performance
219.15 target do not include the admissions applicable to the subsequent hospital admission
219.16 performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting
219.17 this performance target and shall accept payment withholds that may be returned to the
219.18 hospitals if the performance target is achieved.

219.19 (g) Effective for services rendered on or after January 1, 2012, the commissioner shall
219.20 include as part of the performance targets described in paragraph (c) a reduction in the plan's
219.21 hospitalization admission rates for subsequent hospitalizations within 30 days of a previous
219.22 hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare
219.23 enrollees, as determined by the commissioner. To earn the return of the withhold each year,
219.24 the managed care plan or county-based purchasing plan must achieve a qualifying reduction
219.25 of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees,
219.26 excluding enrollees in programs described in subdivisions 23 and 28, of no less than five
219.27 percent compared to the previous calendar year until the final performance target is reached.

219.28 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
219.29 the following calendar year if the managed care plan or county-based purchasing plan
219.30 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
219.31 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold
219.32 so that the commissioner returns a portion of the withheld funds in amounts commensurate
219.33 with achieved reductions in utilization less than the targeted amount.

220.1 The withhold described in this paragraph must continue for each consecutive contract
220.2 period until the plan's subsequent hospitalization rate for medical assistance and
220.3 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
220.4 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
220.5 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
220.6 accept payment withholds that must be returned to the hospitals if the performance target
220.7 is achieved.

220.8 (h) Effective for services rendered on or after January 1, 2013, through December 31,
220.9 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
220.10 this section and county-based purchasing plan payments under section 256B.692 for the
220.11 prepaid medical assistance program. The withheld funds must be returned no sooner than
220.12 July 1 and no later than July 31 of the following year. The commissioner may exclude
220.13 special demonstration projects under subdivision 23.

220.14 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
220.15 withhold three percent of managed care plan payments under this section and county-based
220.16 purchasing plan payments under section 256B.692 for the prepaid medical assistance
220.17 program. The withheld funds must be returned no sooner than July 1 and no later than July
220.18 31 of the following year. The commissioner may exclude special demonstration projects
220.19 under subdivision 23.

220.20 (j) A managed care plan or a county-based purchasing plan under section 256B.692 may
220.21 include as admitted assets under section 62D.044 any amount withheld under this section
220.22 that is reasonably expected to be returned.

220.23 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
220.24 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
220.25 7.

220.26 (l) The return of the withhold under paragraphs (h) and (i) is not subject to the
220.27 requirements of paragraph (c).

220.28 (m) Managed care plans and county-based purchasing plans shall maintain current and
220.29 fully executed agreements for all subcontractors, including bargaining groups, for
220.30 administrative services that are expensed to the state's public health care programs.
220.31 Subcontractor agreements determined to be material, as defined by the commissioner after
220.32 taking into account state contracting and relevant statutory requirements, must be in the
220.33 form of a written instrument or electronic document containing the elements of offer,
220.34 acceptance, consideration, payment terms, scope, duration of the contract, and how the

221.1 subcontractor services relate to state public health care programs. Upon request, the
 221.2 commissioner shall have access to all subcontractor documentation under this paragraph.
 221.3 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
 221.4 to section 13.02.

221.5 (n) Effective for services provided on or after January 1, 2018, through December 31,
 221.6 2018, the commissioner shall withhold two percent of the capitation payment provided to
 221.7 managed care plans under this section, and county-based purchasing plans under section
 221.8 256B.692, for each medical assistance enrollee. The withheld funds must be returned no
 221.9 sooner than July 1 and no later than July 31 of the following year, for capitation payments
 221.10 for enrollees for whom the plan has submitted to the commissioner a verification of coverage
 221.11 form completed and signed by the enrollee. The verification of coverage form must be
 221.12 developed by the commissioner and made available to managed care and county-based
 221.13 purchasing plans. The form must require the enrollee to provide the enrollee's name, street
 221.14 address, and the name of the managed care or county-based purchasing plan selected by or
 221.15 assigned to the enrollee, and must include a signature block that allows the enrollee to attest
 221.16 that the information provided is accurate. A plan shall request that all enrollees complete
 221.17 the verification of coverage form, and shall submit all completed forms to the commissioner
 221.18 by February 28, 2018. If a completed form for an enrollee is not received by the commissioner
 221.19 by that date:

221.20 (1) the commissioner shall not return to the plan funds withheld for that enrollee;

221.21 (2) the commissioner shall cease making capitation payments to the plan for that enrollee,
 221.22 effective with the April 2018 coverage month; and

221.23 (3) the commissioner shall disenroll the enrollee from medical assistance, subject to any
 221.24 enrollee appeal.

221.25 Sec. 40. Minnesota Statutes 2016, section 256B.69, subdivision 9e, is amended to read:

221.26 Subd. 9e. **Financial audits.** ~~(a) The legislative auditor shall conduct or contract with~~
 221.27 ~~vendors to conduct independent third-party financial audits of the information required to~~
 221.28 ~~be provided by audit managed care plans and county-based purchasing plans under~~
 221.29 ~~subdivision 9e, paragraph (b). The audits by the vendors shall be conducted as vendor~~
 221.30 ~~resources permit and in accordance with generally accepted government auditing standards~~
 221.31 ~~issued by the United States Government Accountability Office. The contract with the vendors~~
 221.32 ~~shall be designed and administered so as to render the independent third-party audits eligible~~
 221.33 ~~for a federal subsidy, if available. The contract shall require the audits to include a~~
 221.34 ~~determination of compliance with the federal Medicaid rate certification process to determine~~

222.1 if a managed care plan or county-based purchasing plan used public money in compliance
222.2 with federal and state laws, rules, and in accordance with provisions in the plan's contract
222.3 with the commissioner. The legislative auditor shall conduct the audits in accordance with
222.4 section 3.972, subdivision 2b.

222.5 ~~(b) For purposes of this subdivision, "independent third party" means a vendor that is~~
222.6 ~~independent in accordance with government auditing standards issued by the United States~~
222.7 ~~Government Accountability Office.~~

222.8 Sec. 41. Minnesota Statutes 2016, section 256B.69, is amended by adding a subdivision
222.9 to read:

222.10 Subd. 36. **Competitive bidding and procurement.** (a) For managed care organization
222.11 contracts effective on or after January 1, 2019, the commissioner shall utilize a competitive
222.12 price and technical bidding program on a regional basis for nonelderly adults and children
222.13 who are not eligible on the basis of a disability and are enrolled in medical assistance and
222.14 MinnesotaCare. The commissioner shall establish geographic regions for the purposes of
222.15 competitive price bidding. The commissioner shall not implement a competitive price
222.16 bidding program in a single procurement that exceeds 40 percent of the total enrollment to
222.17 which this paragraph applies except in cases when a managed care organization withdraws
222.18 from their contract with the state, managed care organizations merge, other significant
222.19 market changes occur within the purchasing or health care delivery system, or counties
222.20 agree to a larger procurement. The commissioner shall ensure that there is an adequate
222.21 choice of managed care organizations based on the potential enrollment, in a manner that
222.22 is consistent with the requirements of section 256B.694. The commissioner shall operate
222.23 the competitive bidding program by region, but shall award contracts by county and shall
222.24 allow managed care organizations with a service area consisting of only a portion of a region
222.25 to bid on those counties within their licensed service area only. For purposes of this
222.26 subdivision, "managed care organization" means a demonstration provider as defined in
222.27 subdivision 2, paragraph (b).

222.28 (b) The commissioner shall provide the scoring weight of selection criteria to be assigned
222.29 in the procurement process and include the scoring weight in the request for proposals.
222.30 Substantial weight shall be given to county board resolutions and priority areas identified
222.31 by counties, when that input meets federal requirements under Code of Federal Regulations,
222.32 title 42, part 338.58.

222.33 (c) If a best and final offer is requested, each responding managed care organization
222.34 must be offered the opportunity to submit a best and final offer.

223.1 (d) The commissioner, when evaluating proposals, shall consider network adequacy for
223.2 dental and other services.

223.3 (e) After the managed care organizations are notified about the award determination,
223.4 but before contracts are signed, the commissioner shall meet with any responder upon
223.5 request to discuss their individual results in detail. No evaluation materials will be provided
223.6 in writing until final contracts are signed.

223.7 (f) The commissioner shall provide information to potential responders that outlines the
223.8 goals and objectives of the procurement, in advance of any publication of a request for
223.9 proposals under this section.

223.10 (g) A managed care organization that is aggrieved by the commissioner's decision related
223.11 to the selection of managed care organizations to deliver services in a county or counties
223.12 may appeal the commissioner's decision using the process outlined in section 256B.69,
223.13 subdivision 3a, paragraph (d), except that the recommendation of the three-person mediation
223.14 panel shall be binding on the commissioner.

223.15 (h) The commissioner shall contract for an independent evaluation of the competitive
223.16 price bidding process. The contractor must solicit recommendations from all parties
223.17 participating in the competitive price bidding process for service delivery in calendar year
223.18 2019 on how the competitive price bidding process may be improved for service delivery
223.19 in calendar year 2020 and annually thereafter. The commissioner shall make evaluation
223.20 results available to the public on the department's Web site.

223.21 Sec. 42. Minnesota Statutes 2016, section 256B.75, is amended to read:

223.22 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

223.23 (a) For outpatient hospital facility fee payments for services rendered on or after October
223.24 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
223.25 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
223.26 which there is a federal maximum allowable payment. Effective for services rendered on
223.27 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
223.28 emergency room facility fees shall be increased by eight percent over the rates in effect on
223.29 December 31, 1999, except for those services for which there is a federal maximum allowable
223.30 payment. Services for which there is a federal maximum allowable payment shall be paid
223.31 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
223.32 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
223.33 upper limit. If it is determined that a provision of this section conflicts with existing or

224.1 future requirements of the United States government with respect to federal financial
224.2 participation in medical assistance, the federal requirements prevail. The commissioner
224.3 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
224.4 participation resulting from rates that are in excess of the Medicare upper limitations.

224.5 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
224.6 surgery hospital facility fee services for critical access hospitals designated under section
224.7 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
224.8 cost-finding methods and allowable costs of the Medicare program. Effective for services
224.9 provided on or after July 1, 2015, rates established for critical access hospitals under this
224.10 paragraph for the applicable payment year shall be the final payment and shall not be settled
224.11 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
224.12 year ending in 2016, the rate for outpatient hospital services shall be computed using
224.13 information from each hospital's Medicare cost report as filed with Medicare for the year
224.14 that is two years before the year that the rate is being computed. Rates shall be computed
224.15 using information from Worksheet C series until the department finalizes the medical
224.16 assistance cost reporting process for critical access hospitals. After the cost reporting process
224.17 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
224.18 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
224.19 related to rural health clinics and federally qualified health clinics, divided by ancillary
224.20 charges plus outpatient charges, excluding charges related to rural health clinics and federally
224.21 qualified health clinics.

224.22 (c) Effective for services provided on or after July 1, 2003, rates that are based on the
224.23 Medicare outpatient prospective payment system shall be replaced by a budget neutral
224.24 prospective payment system that is derived using medical assistance data. The commissioner
224.25 shall provide a proposal to the 2003 legislature to define and implement this provision.

224.26 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
224.27 before third-party liability and spenddown, made to hospitals for outpatient hospital facility
224.28 services is reduced by .5 percent from the current statutory rate.

224.29 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
224.30 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility
224.31 services before third-party liability and spenddown, is reduced five percent from the current
224.32 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from
224.33 this paragraph.

225.1 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
 225.2 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
 225.3 hospital facility services before third-party liability and spenddown, is reduced three percent
 225.4 from the current statutory rates. Mental health services and facilities defined under section
 225.5 256.969, subdivision 16, are excluded from this paragraph.

225.6 **EFFECTIVE DATE.** This section is effective July 1, 2017.

225.7 Sec. 43. **[256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC**
 225.8 **HEALTH NURSE HOME VISITS.**

225.9 Effective for services provided on or after January 1, 2018, prenatal and postpartum
 225.10 follow-up home visits provided by public health nurses or registered nurses supervised by
 225.11 a public health nurse using evidence-based models shall be paid \$140 per visit.
 225.12 Evidence-based postpartum follow-up home visits must be administered by home visiting
 225.13 programs that meet the United States Department of Health and Human Services criteria
 225.14 for evidence-based models and are identified by the commissioner of health as eligible to
 225.15 be implemented under the Maternal, Infant, and Early Childhood Home Visiting program.
 225.16 Home visits must target mothers and their children beginning with prenatal visits through
 225.17 age three for the child.

225.18 Sec. 44. Minnesota Statutes 2016, section 256B.766, is amended to read:

225.19 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

225.20 (a) Effective for services provided on or after July 1, 2009, total payments for basic care
 225.21 services, shall be reduced by three percent, except that for the period July 1, 2009, through
 225.22 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance
 225.23 and general assistance medical care programs, prior to third-party liability and spenddown
 225.24 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,
 225.25 occupational therapy services, and speech-language pathology and related services as basic
 225.26 care services. The reduction in this paragraph shall apply to physical therapy services,
 225.27 occupational therapy services, and speech-language pathology and related services provided
 225.28 on or after July 1, 2010.

225.29 (b) Payments made to managed care plans and county-based purchasing plans shall be
 225.30 reduced for services provided on or after October 1, 2009, to reflect the reduction effective
 225.31 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,
 225.32 to reflect the reduction effective July 1, 2010.

226.1 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,
226.2 total payments for outpatient hospital facility fees shall be reduced by five percent from the
226.3 rates in effect on August 31, 2011.

226.4 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
226.5 total payments for ambulatory surgery centers facility fees, medical supplies and durable
226.6 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
226.7 renal dialysis services, laboratory services, public health nursing services, physical therapy
226.8 services, occupational therapy services, speech therapy services, eyeglasses not subject to
226.9 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
226.10 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
226.11 2011.

226.12 (e) Effective for services provided on or after September 1, 2014, payments for
226.13 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory
226.14 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
226.15 and hearing aids not subject to a volume purchase contract shall be increased by three percent
226.16 and payments for outpatient hospital facility fees shall be increased by three percent.
226.17 Payments made to managed care plans and county-based purchasing plans shall not be
226.18 adjusted to reflect payments under this paragraph.

226.19 (f) Payments for medical supplies and durable medical equipment not subject to a volume
226.20 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
226.21 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
226.22 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
226.23 provided on or after July 1, 2015, shall be increased by three percent from the rates as
226.24 determined under paragraphs (i) and (j).

226.25 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
226.26 hospital facility fees, medical supplies and durable medical equipment not subject to a
226.27 volume purchase contract, prosthetics and orthotics, and laboratory services to a hospital
226.28 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),
226.29 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made
226.30 to managed care plans and county-based purchasing plans shall not be adjusted to reflect
226.31 payments under this paragraph.

226.32 (h) This section does not apply to physician and professional services, inpatient hospital
226.33 services, family planning services, mental health services, dental services, prescription

227.1 drugs, medical transportation, federally qualified health centers, rural health centers, Indian
227.2 health services, and Medicare cost-sharing.

227.3 (i) Effective for services provided on or after July 1, 2015, the following categories of
227.4 medical supplies and durable medical equipment shall be individually priced items: enteral
227.5 nutrition and supplies, customized and other specialized tracheostomy tubes and supplies,
227.6 electric patient lifts, and durable medical equipment repair and service. This paragraph does
227.7 not apply to medical supplies and durable medical equipment subject to a volume purchase
227.8 contract, products subject to the preferred diabetic testing supply program, and items provided
227.9 to dually eligible recipients when Medicare is the primary payer for the item. The
227.10 commissioner shall not apply any medical assistance rate reductions to durable medical
227.11 equipment as a result of Medicare competitive bidding.

227.12 (j) Effective for services provided on or after July 1, 2015, medical assistance payment
227.13 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased
227.14 as follows:

227.15 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
227.16 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
227.17 increased by 9.5 percent; and

227.18 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
227.19 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
227.20 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
227.21 being applied after calculation of any increased payment rate under clause (1).

227.22 This paragraph does not apply to medical supplies and durable medical equipment subject
227.23 to a volume purchase contract, products subject to the preferred diabetic testing supply
227.24 program, items provided to dually eligible recipients when Medicare is the primary payer
227.25 for the item, and individually priced items identified in paragraph (i). Payments made to
227.26 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
227.27 rate increases in this paragraph.

227.28 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,
227.29 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective
227.30 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the
227.31 lower of the submitted charge or 47 percent above the Medicare fee schedule rate.

227.32 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2016.

228.1 Sec. 45. **[256B.90] DEFINITIONS.**

228.2 **Subdivision 1. Generally.** For the purposes of sections 256B.90 to 256B.92, the following
228.3 terms have the meanings given.

228.4 **Subd. 2. Commissioner.** "Commissioner" means the commissioner of human services.

228.5 **Subd. 3. Department.** "Department" means the Department of Human Services.

228.6 **Subd. 4. Hospital.** "Hospital" means a public or private institution licensed as a hospital
228.7 under section 144.50 that participates in medical assistance.

228.8 **Subd. 5. Medical assistance.** "Medical assistance" means the state's Medicaid program
228.9 under title XIX of the Social Security Act and administered according to this chapter.

228.10 **Subd. 6. Potentially avoidable complication.** "Potentially avoidable complication"
228.11 means a harmful event or negative outcome with respect to an individual, including an
228.12 infection or surgical complication, that: (1) occurs during the individual's transportation to
228.13 a hospital or long-term care facility or after the individual's admission to a hospital or
228.14 long-term care facility; and (2) may have resulted from the care caused by insufficient
228.15 staffing due to nurses' union strikes in the hospital or long-term care facility by licensed
228.16 practical nurses or registered nurses, lack of care, or treatment provided during the hospital
228.17 or long-term care facility stay or during the individual's transportation to the hospital or
228.18 long-term care facility rather than from a natural progression of an underlying disease.

228.19 **Subd. 7. Potentially avoidable event.** "Potentially avoidable event" means a potentially
228.20 avoidable complication, potentially avoidable readmission, or a combination of those events.

228.21 **Subd. 8. Potentially avoidable readmission.** "Potentially avoidable readmission" means
228.22 a return hospitalization of an individual within a period specified by the commissioner that
228.23 may have resulted from deficiencies in the care or treatment provided to the individual
228.24 during a previous hospital stay or from deficiencies in posthospital discharge follow-up.
228.25 Potentially avoidable readmission does not include a hospital readmission necessitated by
228.26 the occurrence of unrelated events after the discharge. Potentially avoidable readmission
228.27 includes the readmission of an individual to a hospital for: (1) the same condition or
228.28 procedure for which the individual was previously admitted; (2) an infection or other
228.29 complication resulting from care previously provided; or (3) a condition or procedure that
228.30 indicates that a surgical intervention performed during a previous admission was unsuccessful
228.31 in achieving the anticipated outcome.

229.1 Sec. 46. [256B.91] MEDICAL ASSISTANCE OUTCOMES-BASED PAYMENT
229.2 PROGRAM.

229.3 Subdivision 1. Generally. The commissioner must establish and implement a medical
229.4 assistance outcomes-based payment program as a hospital outcomes program under section
229.5 256B.92 to provide hospitals with information and incentives to reduce potentially avoidable
229.6 events.

229.7 Subd. 2. Potentially avoidable event methodology. (a) The commissioner shall issue
229.8 a request for proposals to select a methodology for identifying potentially avoidable events
229.9 and for the costs associated with these events, and for measuring hospital performance with
229.10 respect to these events.

229.11 (b) The commissioner shall develop definitions for each potentially avoidable event
229.12 according to the selected methodology.

229.13 (c) To the extent possible, the methodology shall be one that has been used by other title
229.14 XIX programs under the Social Security Act or by commercial payers in health care outcomes
229.15 performance measurement and in outcome-based payment programs. The methodology
229.16 shall be open, transparent, and available for review by the public.

229.17 Subd. 3. Medical assistance system waste. (a) The commissioner must conduct a
229.18 comprehensive analysis of relevant state databases to identify waste in the medical assistance
229.19 system.

229.20 (b) The analysis must identify instances of potentially avoidable events in medical
229.21 assistance, and the costs associated with these events. The overall estimate of waste must
229.22 be broken down into actionable categories including but not limited to regions, hospitals,
229.23 MCOs, physicians, licensed practical nurses and registered nurses, other unlicensed health
229.24 care personnel, service lines, diagnosis-related groups, medical conditions and procedures,
229.25 patient characteristics, provider characteristics, and medical assistance program type.

229.26 (c) Information collected from this analysis must be utilized in hospital outcomes
229.27 programs described in this section.

229.28 Sec. 47. [256B.92] HOSPITAL OUTCOMES PROGRAM.

229.29 Subdivision 1. Generally. The hospital outcomes program shall:

229.30 (1) target reduction of potentially avoidable readmissions and complications;

229.31 (2) apply to all state acute care hospitals participating in medical assistance. Program
229.32 adjustments may be made for certain types of hospitals; and

230.1 (3) be implemented in two phases: performance reporting and outcomes-based financial
 230.2 incentives.

230.3 Subd. 2. **Phase 1; performance reporting.** (a) The commissioner shall develop and
 230.4 maintain a reporting system to provide each hospital in Minnesota with regular confidential
 230.5 reports regarding the hospital's performance for potentially avoidable readmissions and
 230.6 potentially avoidable complications.

230.7 (b) The commissioner shall:

230.8 (1) conduct ongoing analyses of relevant state claims databases to identify instances of
 230.9 potentially avoidable readmissions and potentially avoidable complications, and the
 230.10 expenditures associated with these events;

230.11 (2) create or locate state readmission and complications norms;

230.12 (3) measure actual-to-expected hospital performance compared to state norms;

230.13 (4) compare hospitals with peers using risk adjustment procedures that account for the
 230.14 severity of illness of each hospital's patients;

230.15 (5) distribute reports to hospitals to provide actionable information to create policies,
 230.16 contracts, or programs designed to improve target outcomes; and

230.17 (6) foster collaboration among hospitals to share best practices.

230.18 (c) A hospital may share the information contained in the outcome performance reports
 230.19 with physicians and other health care providers providing services at the hospital to foster
 230.20 coordination and cooperation in the hospital's outcome improvement and waste reduction
 230.21 initiatives.

230.22 Subd. 3. **Phase 2; outcomes-based financial incentives.** Twelve months after
 230.23 implementation of performance reporting under subdivision 2, the commissioner must
 230.24 establish financial incentives for a hospital to reduce potentially avoidable readmissions
 230.25 and potentially avoidable complications.

230.26 Subd. 4. **Rate adjustment methodology.** (a) The commissioner must adjust the
 230.27 reimbursement that a hospital receives under the All Patients Refined Diagnosis-Related
 230.28 Group inpatient prospective payment system based on the hospital's performance exceeding,
 230.29 or failing to achieve, outcome results based on the rates of potentially avoidable readmissions
 230.30 and potentially avoidable complications.

230.31 (b) The rate adjustment methodology must:

230.32 (1) apply to each hospital discharge;

231.1 (2) determine a hospital-specific potentially avoidable outcome adjustment factor based
231.2 on the hospital's actual versus expected risk-adjusted performance compared to the state
231.3 norm;

231.4 (3) be based on a retrospective analysis of performance prospectively applied;

231.5 (4) include both rewards and penalties; and

231.6 (5) be communicated to a hospital in a clear and transparent manner.

231.7 Subd. 5. **Amendment of contracts.** The commissioner must amend contracts with
231.8 participating hospitals as necessary to incorporate the financial incentives established under
231.9 this section.

231.10 Subd. 6. **Budget neutrality.** The hospital outcomes program shall be implemented in a
231.11 budget-neutral manner with respect to aggregate Medicaid hospital expenditures.

231.12 **Sec. 48. CAPITATION PAYMENT DELAY.**

231.13 (a) The commissioner of human services shall delay the medical assistance capitation
231.14 payment to managed care plans and county-based purchasing plans due in May 2019 and
231.15 the payment due in April 2019 for special needs basic care until July 1, 2019. The payment
231.16 shall be made no earlier than July 1, 2019, and no later than July 31, 2019.

231.17 (b) The commissioner of human services shall delay the medical assistance capitation
231.18 payment to managed care plans and county-based purchasing plans due in May 2021 and
231.19 the payment due in April 2021 for special needs basic care until July 1, 2021. The payment
231.20 shall be made no earlier than July 1, 2021, and no later than July 31, 2021.

231.21 **Sec. 49. COMMISSIONER DUTY TO SEEK FEDERAL APPROVAL.**

231.22 The commissioner of human services shall seek federal approval that is necessary to
231.23 implement Minnesota Statutes, sections 256B.0621, subdivision 10; 256B.0924, subdivision
231.24 4a; and 256B.0625, subdivision 20b, for interactive video contact.

231.25 **Sec. 50. LEGISLATIVE COMMISSION ON MANAGED CARE.**

231.26 Subdivision 1. **Establishment.** (a) A legislative commission is created to study and
231.27 make recommendations to the legislature on issues relating to the competitive bidding
231.28 program and procurement process for the medical assistance and MinnesotaCare contracts
231.29 with managed care organizations for nonelderly, nondisabled adults and children enrollees.

232.1 (b) For purposes of this section, "managed care organization" means a demonstration
232.2 provider as defined under Minnesota Statutes, section 256B.69, subdivision 2.

232.3 Subd. 2. **Membership.** (a) The commission consists of:

232.4 (1) four members of the senate, two members appointed by the senate majority leader
232.5 and two members appointed by the senate minority leader;

232.6 (2) four members of the house of representatives, two members appointed by the speaker
232.7 of the house and two members appointed by the minority leader; and

232.8 (3) the commissioner of human services or the commissioner's designee.

232.9 (b) The appointing authorities must make their appointments by July 1, 2017.

232.10 (c) The ranking senator from the majority party appointed to the commission shall
232.11 convene the first meeting no later than September 1, 2017.

232.12 (d) The commission shall elect a chair among its members at the first meeting.

232.13 (e) Members serve without compensation or reimbursement for expenses, except that
232.14 legislative members may receive per diem and be reimbursed for expenses as provided in
232.15 the rules governing their respective bodies.

232.16 Subd. 3. **Staff.** The commissioner of human services shall provide staff and administrative
232.17 and research services, as needed, to the commission.

232.18 Subd. 4. **Duties.** (a) The commission shall study, review, and make recommendations
232.19 on the competitive bidding process for the managed care contracts that provide services to
232.20 the nonelderly, nondisabled adults and children enrolled in medical assistance and
232.21 MinnesotaCare. When reviewing the competitive bidding process, the commission shall
232.22 consider and make recommendations on the following:

232.23 (1) the number of geographic regions to be established for competitive bidding and each
232.24 procurement cycle and the criteria to be used in determining the minimum number of
232.25 managed care organizations to serve each region or statistical area;

232.26 (2) the specifications of the request for proposals, including whether managed care
232.27 organizations must address in their proposals priority areas identified by counties;

232.28 (3) the criteria to be used to determine whether managed care organizations will be
232.29 requested to provide a best and final offer;

232.30 (4) the evaluation process that the commissioner must consider when evaluating each
232.31 proposal, including the scoring weight to be given when there is a county board resolution

233.1 identifying a managed care organization preference, and whether consideration shall be
 233.2 given to network adequacy for such services as dental, mental health, and primary care;

233.3 (5) the notification process to inform managed care organizations about the award
 233.4 determinations, but before the contracts are signed;

233.5 (6) process for appealing the commissioner's decision on the selection of a managed
 233.6 care plan or county-based purchasing plan in a county or counties; and

233.7 (7) whether an independent evaluation of the competitive bidding process is necessary,
 233.8 and if so, what the evaluation should entail.

233.9 (b) The commissioner shall consider the frequency of the procurement process in terms
 233.10 of how often the commissioner should conduct the procurement of managed care contracts
 233.11 and whether procurement should be conducted on a statewide basis or at staggered times
 233.12 for a limited number of counties within a specified region.

233.13 (c) The commission shall review proposed legislation that incorporates new federal
 233.14 regulations into managed care statutes, including the recodification of the managed care
 233.15 requirements in Minnesota Statutes, sections 256B.69 and 256B.692.

233.16 (d) The commission shall study, review, and make recommendations on a process that
 233.17 meets federal regulations for ensuring that provider rate increases passed by the legislature
 233.18 and incorporated into the capitated rates paid to managed care organizations are recognized
 233.19 in the rates paid by the managed care organizations to the providers while still providing
 233.20 managed care organizations the flexibility in negotiating rates paid to their provider networks.

233.21 (e) The commission shall consult with interested stakeholders and may solicit public
 233.22 testimony, as deemed necessary.

233.23 Subd. 5. **Report.** (a) The commission shall report its recommendations to the chairs and
 233.24 ranking minority members of the legislative committees with jurisdiction over health and
 233.25 human services policy and finance by February 15, 2018. The report shall include any draft
 233.26 legislation necessary to implement the recommendations.

233.27 (b) The commission shall provide preliminary recommendations to the commissioner
 233.28 of human services to be used by the commissioner if the commissioner decides to conduct
 233.29 a procurement for managed care contracts for the 2019 contract year.

233.30 Subd. 6. **Open meetings.** The commission is subject to Minnesota Statutes, section
 233.31 3.055.

233.32 Subd. 7. **Expiration.** This section expires June 30, 2018.

234.1 Sec. 51. **HEALTH CARE ACCESS FUND ASSESSMENT.**

234.2 (a) The commissioner of human services, in consultation with the commissioner of
234.3 management and budget, shall assess any federal health care reform legislation passed at
234.4 the federal level on its effect on the MinnesotaCare program and the need for the health
234.5 care access fund as its continued source of funding.

234.6 (b) The commissioner shall report to the chairs and ranking minority members of the
234.7 legislative committees with jurisdiction over health care policy and finance within 90 days
234.8 of the passage of any federal health care reform legislation.

234.9 Sec. 52. **OPIOID USE AND ACUPUNCTURE STUDY.**

234.10 (a) The commissioner of human services shall study the use of opiates for the treatment
234.11 of chronic pain conditions when acupuncture services are also part of the treatment for
234.12 chronic pain as compared to opiate use among medical assistance recipients who are not
234.13 receiving acupuncture. In comparing the sample groups, the commissioner shall look at
234.14 each group's opiate use and other services as identified by the commissioner.

234.15 (b) The aggregate findings of the study shall be submitted by the commissioner to the
234.16 chairs and ranking minority members of the legislative committees with jurisdiction over
234.17 health and human services policy and finance by February 15, 2018. The report shall not
234.18 contain or disclose any patient identifying data.

234.19 Sec. 53. **ENCOUNTER REPORTING OF 340B ELIGIBLE DRUGS.**

234.20 (a) The commissioner of human services, in consultation with federally qualified health
234.21 centers, managed care organizations, and contract pharmacies shall develop a report on the
234.22 feasibility of a process to identify and report at point of sale the 340B drugs that are dispensed
234.23 to enrollees of managed care organizations who are patients of a federally qualified health
234.24 center to exclude these claims from the Medicaid drug rebate program and ensure that
234.25 duplicate discounts for drugs do not occur.

234.26 (b) By January 1, 2018, the commissioner shall present the report to the chairs and
234.27 ranking minority members of the legislative committees with jurisdiction over medical
234.28 assistance.

234.29 Sec. 54. **RATE-SETTING ANALYSIS REPORT.**

234.30 The commissioner of human services shall conduct a comprehensive analysis report of
234.31 the current rate-setting methodology for outpatient, professional, and physician services

235.1 that do not have a cost-based, federally mandated, or contracted rate. The report shall include
 235.2 recommendations for changes to the existing fee schedule that utilizes the Resource-Based
 235.3 Relative Value System (RBRVS), and alternate payment methodologies for services that
 235.4 do not have relative values, to simplify the fee for service medical assistance rate structure
 235.5 and to improve consistency and transparency. In developing the report, the commissioner
 235.6 shall consult with outside experts in Medicaid financing. The commissioner shall provide
 235.7 a report on the analysis to the chairs and ranking minority members of the legislative
 235.8 committees with jurisdiction over health and human services finance by November 1, 2019.

235.9 **Sec. 55. STUDY OF PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT**
 235.10 **AND SUPPLIES.**

235.11 The commissioner of human services shall study the impact of basing medical assistance
 235.12 payment for durable medical equipment and medical supplies on Medicare payment rates,
 235.13 as limited by the payment provisions in the 21st Century Cures Act, Public Law 114-255,
 235.14 on access by medical assistance enrollees to these items. The study must include
 235.15 recommendations for ensuring and improving access by medical assistance enrollees to
 235.16 durable medical equipment and medical supplies. The commissioner shall report study
 235.17 results and recommendations to the chairs and ranking minority members of the legislative
 235.18 committees with jurisdiction over health and human services policy and finance by July 1,
 235.19 2020.

235.20 **Sec. 56. REVISOR'S INSTRUCTION.**

235.21 The revisor of statutes, in the next edition of Minnesota Statutes, shall change the term
 235.22 "health care delivery system" and similar terms to "integrated health partnership" and similar
 235.23 terms, wherever it appears in Minnesota Statutes, section 256B.0755.

235.24 **Sec. 57. REPEALER.**

235.25 Minnesota Statutes 2016, section 256B.64, is repealed.

235.26 **ARTICLE 5**

235.27 **HEALTH INSURANCE**

235.28 Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

235.29 Subdivision 1. **Reference.** (a) Any reference to "standard provisions" which may appear
 235.30 in other sections and which refer to accident and sickness or accident and health insurance
 235.31 shall hereinafter be construed as referring to accident and sickness policy provisions.

236.1 (b) Notwithstanding paragraph (a), the following do not apply to health plans:

236.2 (1) subdivision 2, clauses (4) to (10) and (12);

236.3 (2) subdivision 3, clauses (1) and (3) to (7); and

236.4 (3) subdivisions 6 and 10.

236.5 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 236.6 renewed on or after January 1, 2018.

236.7 Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

236.8 Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain
 236.9 a provision which permits continuation of coverage under the policy for the insured's ~~former~~
 236.10 ~~spouse and dependent children upon~~, which is defined as required by section 62A.302, and
 236.11 former spouse, who was covered on the day before the entry of a valid decree of dissolution
 236.12 of marriage. The coverage shall be continued until the earlier of the following dates:

236.13 (a) the date the insured's former spouse becomes covered under any other group health
 236.14 plan; or

236.15 (b) the date coverage would otherwise terminate under the policy.

236.16 If the coverage is provided under a group policy, any required premium contributions
 236.17 for the coverage shall be paid by the insured on a monthly basis to the group policyholder
 236.18 for remittance to the insurer. The policy must require the group policyholder to, upon request,
 236.19 provide the insured with written verification from the insurer of the cost of this coverage
 236.20 promptly at the time of eligibility for this coverage and at any time during the continuation
 236.21 period. In no event shall the amount of premium charged exceed 102 percent of the cost to
 236.22 the plan for such period of coverage for other similarly situated spouses and dependent
 236.23 children with respect to whom the marital relationship has not dissolved, without regard to
 236.24 whether such cost is paid by the employer or employee.

236.25 Upon request by the insured's former spouse, who was covered on the day before the
 236.26 entry of a valid decree of dissolution, or dependent child, a health carrier must provide the
 236.27 instructions necessary to enable the child or former spouse to elect continuation of coverage.

236.28 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 236.29 renewed on or after January 1, 2018.

236.30 Sec. 3. Minnesota Statutes 2016, section 62A.3075, is amended to read:

236.31 **62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.**

237.1 (a) A health plan company that provides coverage under a health plan for cancer
237.2 chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance
237.3 amount for a prescribed, orally administered anticancer medication that is used to kill or
237.4 slow the growth of cancerous cells than what the health plan requires for an intravenously
237.5 administered or injected cancer medication that is provided, regardless of formulation or
237.6 benefit category determination by the health plan company.

237.7 (b) A health plan company must not achieve compliance with this section by imposing
237.8 an increase in co-payment, deductible, or coinsurance amount for an intravenously
237.9 administered or injected cancer chemotherapy agent covered under the health plan.

237.10 (c) Nothing in this section shall be interpreted to prohibit a health plan company from
237.11 requiring prior authorization or imposing other appropriate utilization controls in approving
237.12 coverage for any chemotherapy.

237.13 (d) A plan offered by the commissioner of management and budget under section 43A.23
237.14 is deemed to be at parity and in compliance with this section.

237.15 (e) A health plan company is in compliance with this section if it does not include orally
237.16 administered anticancer medication in the fourth tier of its pharmacy benefit.

237.17 (f) A health plan company that provides coverage under a health plan for cancer
237.18 chemotherapy treatment must indicate the level of coverage for orally administered anticancer
237.19 medication within its pharmacy benefit filing with the commissioner.

237.20 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to health
237.21 plans offered, sold, issued, or renewed on or after that date.

237.22 Sec. 4. Minnesota Statutes 2016, section 62D.105, is amended to read:

237.23 **62D.105 COVERAGE OF CURRENT SPOUSE, FORMER SPOUSE, AND**
237.24 **CHILDREN.**

237.25 Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to
237.26 covering the enrollee also provides coverage to the spouse ~~and~~₂ dependent children, which
237.27 is defined as required by section 62A.302, and former spouse who was covered on the day
237.28 before the entry of a valid decree of dissolution of marriage, of the enrollee shall: (1) permit
237.29 the spouse, former spouse, and dependent children to elect to continue coverage when the
237.30 enrollee becomes enrolled for benefits under title XVIII of the Social Security Act
237.31 (Medicare); and (2) permit the dependent children to continue coverage when they cease
237.32 to be dependent children under the generally applicable requirement of the plan.

238.1 Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be
 238.2 continued until the earlier of the following dates:

238.3 (1) the date coverage would otherwise terminate under the contract;

238.4 (2) 36 months after continuation by the spouse, former spouse, or dependent was elected;

238.5 or

238.6 (3) the date the spouse, former spouse, or dependent children become covered under
 238.7 another group health plan or Medicare.

238.8 If coverage is provided under a group policy, any required fees for the coverage shall
 238.9 be paid by the enrollee on a monthly basis to the group contract holder for remittance to the
 238.10 health maintenance organization. In no event shall the fee charged exceed 102 percent of
 238.11 the cost to the plan for such coverage for other similarly situated spouse and dependent
 238.12 children to whom subdivision 1 is not applicable, without regard to whether such cost is
 238.13 paid by the employer or employee.

238.14 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 238.15 renewed on or after January 1, 2018.

238.16 Sec. 5. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

238.17 Subd. 11. ~~Essential health benefits package~~ **Affordable Care Act compliant plans.**
 238.18 ~~For individual or small group health plans that include the essential health benefits package~~
 238.19 ~~and are any policy of accident and health insurance subject to the requirements of the~~
 238.20 Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold,
 238.21 issued, or renewed on or after January 1, 2014 2018, the requirements of this section do not
 238.22 apply.

238.23 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 238.24 renewed on or after January 1, 2018.

238.25 Sec. 6. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

238.26 Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for
 238.27 certification of a plan of health coverage as a qualified plan or a qualified Medicare
 238.28 supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall
 238.29 make a determination within 90 days as to whether the plan is qualified. All plans of health
 238.30 coverage, except Medicare supplement policies, shall be labeled as "qualified" or
 238.31 "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified
 238.32 plans shall indicate whether they are number one, two, or three coverage plans. For any

239.1 policy of accident and health insurance subject to the requirements of the Affordable Care
 239.2 Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or
 239.3 renewed on or after January 1, 2018, the requirements of this section do not apply.

239.4 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 239.5 renewed on or after January 1, 2018.

239.6 Sec. 7. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to
 239.7 read:

239.8 Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health
 239.9 insurance subject to the requirements of the Affordable Care Act, as defined under section
 239.10 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1,
 239.11 2018, the requirements of this section do not apply.

239.12 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
 239.13 renewed on or after January 1, 2018.

239.14 Sec. 8. Minnesota Statutes 2016, section 317A.811, subdivision 1, is amended to read:

239.15 Subdivision 1. **When required.** (a) Except as provided in subdivision 6, the following
 239.16 corporations shall notify the attorney general of their intent to dissolve, merge, or consolidate,
 239.17 or to transfer all or substantially all of their assets:

239.18 (1) a corporation that holds assets for a charitable purpose as defined in section 501B.35,
 239.19 subdivision 2; ~~or~~

239.20 (2) a health maintenance organization operating under chapter 62D;

239.21 (3) a service plan corporation operating under chapter 62C; or

239.22 ~~(2)~~ (4) a corporation that is exempt under section 501(c)(3) of the Internal Revenue Code
 239.23 of 1986, or any successor section.

239.24 (b) The notice must include:

239.25 (1) the purpose of the corporation that is giving the notice;

239.26 (2) a list of assets owned or held by the corporation for charitable purposes;

239.27 (3) a description of restricted assets and purposes for which the assets were received;

239.28 (4) a description of debts, obligations, and liabilities of the corporation;

239.29 (5) a description of tangible assets being converted to cash and the manner in which
 239.30 they will be sold;

- 240.1 (6) anticipated expenses of the transaction, including attorney fees;
- 240.2 (7) a list of persons to whom assets will be transferred, if known;
- 240.3 (8) the purposes of persons receiving the assets; and
- 240.4 (9) the terms, conditions, or restrictions, if any, to be imposed on the transferred assets.

240.5 The notice must be signed on behalf of the corporation by an authorized person.

240.6 Sec. 9. Minnesota Statutes 2016, section 317A.811, is amended by adding a subdivision
240.7 to read:

240.8 Subd. 1a. **Nonprofit health care entity; notice required.** A corporation that is a health
240.9 maintenance organization or a service plan corporation is subject to notice requirements for
240.10 certain transactions under section 317A.814.

240.11 Sec. 10. **[317A.814] NONPROFIT HEALTH CARE ENTITY CONVERSIONS.**

240.12 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

240.13 (b) "Commissioner" means the commissioner of commerce if the nonprofit health care
240.14 entity at issue is a service plan corporation operating under chapter 62C, and the
240.15 commissioner of health if the nonprofit health care entity at issue is a health maintenance
240.16 organization operating under chapter 62D.

240.17 (c) "Conversion benefit entity" means a foundation, corporation, limited liability
240.18 company, trust, partnership, or other entity that receives public benefit assets, or their value,
240.19 in connection with a conversion transaction.

240.20 (d) "Conversion transaction" or "transaction" means a transaction in which a nonprofit
240.21 health care entity merges, consolidates, converts, or transfers all or a substantial portion of
240.22 its assets to an entity that is not a nonprofit corporation organized under this chapter that is
240.23 also exempt under United States Code, title 26, section 501(c)(3). The substitution of a new
240.24 corporate member that transfers the control, responsibility for, or governance of a nonprofit
240.25 health care entity is also considered a transaction for purposes of this section.

240.26 (e) "Family member" means a spouse, parent, or child or other legal dependent.

240.27 (f) "Nonprofit health care entity" means a service plan corporation operating under
240.28 chapter 62C and a health maintenance organization operating under chapter 62D.

240.29 (g) "Public benefit assets" means:

241.1 (1) assets that represent net earnings that were required to be devoted to the nonprofit
241.2 purposes of the health maintenance organization according to Minnesota Statutes 2016,
241.3 section 62D.12; and

241.4 (2) other assets that are identified as dedicated for a charitable or public purpose.

241.5 (h) "Related organization" has the meaning given in section 317A.011.

241.6 Subd. 2. **Private inurement.** A nonprofit health care entity must not enter into a
241.7 conversion transaction if a person who has been an officer, director, or other executive of
241.8 the nonprofit health care entity, or of a related organization, or a family member of that
241.9 person:

241.10 (1) has or will receive any compensation or other financial benefit, directly or indirectly,
241.11 in connection with the conversion transaction;

241.12 (2) has held or will hold, regardless of whether guaranteed or contingent, an ownership
241.13 stake, stock, securities, investment, or other financial interest in, or receive any type of
241.14 onetime compensation or other financial benefit from, any entity to which the nonprofit
241.15 health care entity transfers public benefit assets in connection with a conversion transaction;
241.16 or

241.17 (3) has held or will hold, regardless of whether guaranteed or contingent, an ownership
241.18 stake, stock, securities, investment, or other financial interest in, or receive any type of
241.19 compensation or other financial benefit from, any entity that has or will have a business
241.20 relationship with any entity to which the nonprofit health care entity transfers public benefit
241.21 assets in connection with a conversion transaction.

241.22 Subd. 3. **Attorney general notice required.** (a) Before entering into a conversion
241.23 transaction, the nonprofit health care entity must notify the attorney general as specified
241.24 under section 317A.811, subdivision 1. The notice required by this subdivision also must
241.25 include an itemization of the nonprofit health care entity's public benefit assets and the
241.26 valuation that the entity attributes to those assets, a proposed plan for distribution of the
241.27 value of those assets to a conversion benefit entity that meets the requirements of subdivision
241.28 5, and other information from the health maintenance organization or the proposed conversion
241.29 benefit entity that the attorney general reasonably considers necessary for review of the
241.30 proposed transaction.

241.31 (b) A copy of the notice and other information required under this subdivision must be
241.32 given to the commissioner.

242.1 Subd. 4. Review elements. In exercising the powers under this chapter, the attorney
242.2 general, in consultation with the commissioner, shall consider any factors the attorney
242.3 general considers relevant, including whether:

242.4 (1) the proposed transaction complies with this chapter and chapter 501B and other
242.5 applicable laws;

242.6 (2) the proposed transaction involves or constitutes a breach of charitable trust;

242.7 (3) the nonprofit health care entity will receive full and fair value for its public benefit
242.8 assets;

242.9 (4) the full and fair value of the public benefit assets to be transferred has been
242.10 manipulated in a manner that causes or has caused the value of the assets to decrease;

242.11 (5) the proceeds of the proposed transaction will be used consistent with the public
242.12 benefit for which the assets are held by the nonprofit health care entity;

242.13 (6) the proposed transaction will result in a breach of fiduciary duty, as determined by
242.14 the attorney general, including whether:

242.15 (i) conflicts of interest exist related to payments to or benefits conferred upon officers,
242.16 directors, board members, and executives of the nonprofit health care entity or a related
242.17 organization;

242.18 (ii) the nonprofit health care entity's board of directors exercised reasonable care and
242.19 due diligence in deciding to pursue the transaction, in selecting the entity with which to
242.20 pursue the transaction, and in negotiating the terms and conditions of the transaction; and

242.21 (iii) the nonprofit health care entity's board of directors considered all reasonably viable
242.22 alternatives, including any competing offers for its public benefit assets, or alternative
242.23 transactions;

242.24 (7) the transaction will result in private inurement to any person, including owners,
242.25 stakeholders, or directors, officers, or key staff of the nonprofit health care entity or entity
242.26 to which the nonprofit health care entity proposes to transfer public benefit assets;

242.27 (8) the conversion benefit entity meets the requirements of subdivision 5; and

242.28 (9) the attorney general has been provided with sufficient information by the nonprofit
242.29 health care entity to adequately evaluate the proposed transaction and the effects on the
242.30 public, provided the attorney general has notified the nonprofit health care entity or the
242.31 proposed conversion benefit entity of any inadequacy of the information and has provided
242.32 a reasonable opportunity to remedy that inadequacy.

243.1 In addition, the attorney general shall consider the public comments received regarding
 243.2 the proposed conversion transaction and the proposed transaction's likely effect on the
 243.3 availability, accessibility, and affordability of health care services to the public.

243.4 Subd. 5. **Conversion benefit entity requirements.** (a) A conversion benefit entity must
 243.5 be an existing or new nonprofit corporation and also be exempt under United States Code,
 243.6 title 26, section 501(c)(3).

243.7 (b) The conversion benefit entity must have in place procedures and policies to prohibit
 243.8 conflicts of interest, including but not limited to prohibiting conflicts of interests relating
 243.9 to any grant-making activities that may benefit:

243.10 (1) the directors, officers, or other executives of the conversion benefit entity;

243.11 (2) any entity to which the nonprofit health care entity transfers any public benefit assets
 243.12 in connection with a conversion transaction; or

243.13 (3) any directors, officers, or other executives of any entity to which the nonprofit health
 243.14 care entity transfers any public benefit assets in connection with a conversion transaction.

243.15 (c) The charitable purpose and grant-making functions of the conversion benefit entity
 243.16 must be dedicated to meeting the health care needs of the people of this state.

243.17 Subd. 6. **Public comment.** The attorney general may solicit public comment regarding
 243.18 the proposed conversion transaction. The attorney general may hold one or more public
 243.19 meetings or solicit written or electronic correspondence. If a meeting is held, notice of the
 243.20 meeting must be published in a qualified newspaper of general circulation in this state at
 243.21 least seven days before the meeting.

243.22 Subd. 7. **Relation to other law.** (a) This section is in addition to, and does not affect or
 243.23 limit any power, remedy, or responsibility of a health maintenance organization, service
 243.24 plan corporation, a conversion benefit entity, the attorney general, or the commissioner
 243.25 under this chapter, chapter 62C, 62D, 501B, or other law.

243.26 (b) Nothing in this section authorizes a nonprofit health care entity to enter into a
 243.27 conversion transaction not otherwise permitted under this chapter.

243.28 Sec. 11. Laws 2017, chapter 2, article 1, section 5, is amended to read:

243.29 Sec. 5. **SUNSET.**

243.30 This article ~~sunsets June 30~~, other than section 2, subdivision 5, and section 3, sunsets
 243.31 August 31, 2018.

244.1 Sec. 12. Laws 2017, chapter 2, article 1, section 7, is amended to read:

244.2 Sec. 7. **APPROPRIATIONS.**

244.3 (a) \$311,788,000 in fiscal year 2017 is appropriated from the general fund to the
244.4 commissioner of management and budget for premium assistance under section 2. This
244.5 appropriation is onetime and is available through ~~June 30~~ August 31, 2018.

244.6 (b) \$157,000 in fiscal year 2017 is appropriated from the general fund to the legislative
244.7 auditor for purposes of section 3. This appropriation is onetime.

244.8 (c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018,
244.9 shall be transferred ~~on July 1~~ no later than August 31, 2018, from the general fund to the
244.10 budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

244.11 ARTICLE 6

244.12 DIRECT CARE AND TREATMENT

244.13 Section 1. Minnesota Statutes 2016, section 253B.10, subdivision 1, is amended to read:

244.14 Subdivision 1. **Administrative requirements.** (a) When a person is committed, the
244.15 court shall issue a warrant or an order committing the patient to the custody of the head of
244.16 the treatment facility. The warrant or order shall state that the patient meets the statutory
244.17 criteria for civil commitment.

244.18 (b) The commissioner shall prioritize patients being admitted from jail or a correctional
244.19 institution who are:

244.20 (1) ordered confined in a state hospital for an examination under Minnesota Rules of
244.21 Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

244.22 (2) under civil commitment for competency treatment and continuing supervision under
244.23 Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

244.24 (3) found not guilty by reason of mental illness under Minnesota Rules of Criminal
244.25 Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be
244.26 detained in a state hospital or other facility pending completion of the civil commitment
244.27 proceedings; or

244.28 (4) committed under this chapter to the commissioner after dismissal of the patient's
244.29 criminal charges.

245.1 Patients described in this paragraph must be admitted to a service operated by the
245.2 commissioner within 48 hours. The commitment must be ordered by the court as provided
245.3 in section 253B.09, subdivision 1, paragraph (c).

245.4 (c) Upon the arrival of a patient at the designated treatment facility, the head of the
245.5 facility shall retain the duplicate of the warrant and endorse receipt upon the original warrant
245.6 or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed
245.7 in the court of commitment. After arrival, the patient shall be under the control and custody
245.8 of the head of the treatment facility.

245.9 (d) Copies of the petition for commitment, the court's findings of fact and conclusions
245.10 of law, the court order committing the patient, the report of the examiners, and the prepetition
245.11 report shall be provided promptly to the treatment facility. This information shall also be
245.12 provided by the head of the treatment facility to treatment facility staff in a consistent and
245.13 timely manner and pursuant to all applicable laws.

245.14 Sec. 2. Minnesota Statutes 2016, section 253B.22, subdivision 1, is amended to read:

245.15 Subdivision 1. **Establishment.** The commissioner shall establish a review board ~~of three~~
245.16 ~~or more persons for each regional center~~ to review the admission and retention of its patients
245.17 receiving services under this chapter. The review board shall be comprised of two members
245.18 and one chair. Each board member shall be selected and appointed by the commissioner.
245.19 The appointed members shall be limited to one term of no more than three years and no
245.20 board member can serve more than three consecutive three-year terms. One member shall
245.21 be qualified in the diagnosis of mental illness, developmental disability, or chemical
245.22 dependency, and one member shall be an attorney. The commissioner may, upon written
245.23 request from the appropriate federal authority, establish a review panel for any federal
245.24 treatment facility within the state to review the admission and retention of patients
245.25 hospitalized under this chapter. For any review board established for a federal treatment
245.26 facility, one of the persons appointed by the commissioner shall be the commissioner of
245.27 veterans affairs or the commissioner's designee.

245.28 Sec. 3. **REVIEW OF ALTERNATIVES TO STATE-OPERATED GROUP HOMES**
245.29 **HOUSING ONE PERSON.**

245.30 The commissioner of human services shall review the potential for, and the viability of,
245.31 alternatives to state-operated group homes housing one person. The intent is to create housing
245.32 options for individuals who do not belong in an institutionalized setting, but need additional
245.33 support before transitioning to a more independent community placement. The review shall

246.1 include an analysis of existing housing settings operated by counties and private providers,
246.2 as well as the potential for new housing settings, and determine the viability for use by
246.3 state-operated services. The commissioner shall seek input from interested stakeholders as
246.4 part of the review. An update, including alternatives identified, will be provided by the
246.5 commissioner to the members of the legislative committees having jurisdiction over human
246.6 services issues no later than January 15, 2018.

246.7 **ARTICLE 7**

246.8 **CHILDREN AND FAMILIES**

246.9 Section 1. Minnesota Statutes 2016, section 13.32, is amended by adding a subdivision
246.10 to read:

246.11 Subd. 12. **Access by welfare system.** County personnel in the welfare system may
246.12 request access to education data in order to coordinate services for a student or family. The
246.13 request must be submitted to the chief administrative officer of the school and must include
246.14 the basis for the request and a description of the information that is requested. The chief
246.15 administrative officer must provide a copy of the request to the parent or legal guardian of
246.16 the student who is the subject of the request, along with a form the parent or legal guardian
246.17 may execute to consent to the release of specified information to the requester. Education
246.18 data may be released under this subdivision only if the parent or legal guardian gives
246.19 informed consent to the release.

246.20 Sec. 2. Minnesota Statutes 2016, section 13.46, subdivision 1, is amended to read:

246.21 Subdivision 1. **Definitions.** As used in this section:

246.22 (a) "Individual" means an individual according to section 13.02, subdivision 8, but does
246.23 not include a vendor of services.

246.24 (b) "Program" includes all programs for which authority is vested in a component of the
246.25 welfare system according to statute or federal law, including, but not limited to, Native
246.26 American tribe programs that provide a service component of the welfare system, the aid
246.27 to families with dependent children program formerly codified in sections 256.72 to 256.87,
246.28 Minnesota family investment program, temporary assistance for needy families program,
246.29 medical assistance, general assistance, general assistance medical care formerly codified in
246.30 chapter 256D, child care assistance program, and child support collections.

246.31 (c) "Welfare system" includes the Department of Human Services, local social services
246.32 agencies, county welfare agencies, county public health agencies, county veteran services

247.1 agencies, county housing agencies, private licensing agencies, the public authority responsible
247.2 for child support enforcement, human services boards, community mental health center
247.3 boards, state hospitals, state nursing homes, the ombudsman for mental health and
247.4 developmental disabilities, Native American tribes to the extent a tribe provides a service
247.5 component of the welfare system, and persons, agencies, institutions, organizations, and
247.6 other entities under contract to any of the above agencies to the extent specified in the
247.7 contract.

247.8 (d) "Mental health data" means data on individual clients and patients of community
247.9 mental health centers, established under section 245.62, mental health divisions of counties
247.10 and other providers under contract to deliver mental health services, or the ombudsman for
247.11 mental health and developmental disabilities.

247.12 (e) "Fugitive felon" means a person who has been convicted of a felony and who has
247.13 escaped from confinement or violated the terms of probation or parole for that offense.

247.14 (f) "Private licensing agency" means an agency licensed by the commissioner of human
247.15 services under chapter 245A to perform the duties under section 245A.16.

247.16 Sec. 3. Minnesota Statutes 2016, section 13.46, subdivision 2, is amended to read:

247.17 Subd. 2. **General.** (a) Data on individuals collected, maintained, used, or disseminated
247.18 by the welfare system are private data on individuals, and shall not be disclosed except:

247.19 (1) according to section 13.05;

247.20 (2) according to court order;

247.21 (3) according to a statute specifically authorizing access to the private data;

247.22 (4) to an agent of the welfare system and an investigator acting on behalf of a county,
247.23 the state, or the federal government, including a law enforcement person or attorney in the
247.24 investigation or prosecution of a criminal, civil, or administrative proceeding relating to the
247.25 administration of a program;

247.26 (5) to personnel of the welfare system who require the data to verify an individual's
247.27 identity; determine eligibility, amount of assistance, and the need to provide services to an
247.28 individual or family across programs; coordinate services for an individual or family;
247.29 evaluate the effectiveness of programs; assess parental contribution amounts; and investigate
247.30 suspected fraud;

247.31 (6) to administer federal funds or programs;

247.32 (7) between personnel of the welfare system working in the same program;

248.1 (8) to the Department of Revenue to assess parental contribution amounts for purposes
248.2 of section 252.27, subdivision 2a, administer and evaluate tax refund or tax credit programs
248.3 and to identify individuals who may benefit from these programs. The following information
248.4 may be disclosed under this paragraph: an individual's and their dependent's names, dates
248.5 of birth, Social Security numbers, income, addresses, and other data as required, upon
248.6 request by the Department of Revenue. Disclosures by the commissioner of revenue to the
248.7 commissioner of human services for the purposes described in this clause are governed by
248.8 section 270B.14, subdivision 1. Tax refund or tax credit programs include, but are not limited
248.9 to, the dependent care credit under section 290.067, the Minnesota working family credit
248.10 under section 290.0671, the property tax refund and rental credit under section 290A.04,
248.11 and the Minnesota education credit under section 290.0674;

248.12 (9) between the Department of Human Services, the Department of Employment and
248.13 Economic Development, and when applicable, the Department of Education, for the following
248.14 purposes:

248.15 (i) to monitor the eligibility of the data subject for unemployment benefits, for any
248.16 employment or training program administered, supervised, or certified by that agency;

248.17 (ii) to administer any rehabilitation program or child care assistance program, whether
248.18 alone or in conjunction with the welfare system;

248.19 (iii) to monitor and evaluate the Minnesota family investment program or the child care
248.20 assistance program by exchanging data on recipients and former recipients of food support,
248.21 cash assistance under chapter 256, 256D, 256J, or 256K, child care assistance under chapter
248.22 119B, medical programs under chapter 256B or 256L, or a medical program formerly
248.23 codified under chapter 256D; and

248.24 (iv) to analyze public assistance employment services and program utilization, cost,
248.25 effectiveness, and outcomes as implemented under the authority established in Title II,
248.26 Sections 201-204 of the Ticket to Work and Work Incentives Improvement Act of 1999.
248.27 Health records governed by sections 144.291 to 144.298 and "protected health information"
248.28 as defined in Code of Federal Regulations, title 45, section 160.103, and governed by Code
248.29 of Federal Regulations, title 45, parts 160-164, including health care claims utilization
248.30 information, must not be exchanged under this clause;

248.31 (10) to appropriate parties in connection with an emergency if knowledge of the
248.32 information is necessary to protect the health or safety of the individual or other individuals
248.33 or persons;

249.1 (11) data maintained by residential programs as defined in section 245A.02 may be
249.2 disclosed to the protection and advocacy system established in this state according to Part
249.3 C of Public Law 98-527 to protect the legal and human rights of persons with developmental
249.4 disabilities or other related conditions who live in residential facilities for these persons if
249.5 the protection and advocacy system receives a complaint by or on behalf of that person and
249.6 the person does not have a legal guardian or the state or a designee of the state is the legal
249.7 guardian of the person;

249.8 (12) to the county medical examiner or the county coroner for identifying or locating
249.9 relatives or friends of a deceased person;

249.10 (13) data on a child support obligor who makes payments to the public agency may be
249.11 disclosed to the Minnesota Office of Higher Education to the extent necessary to determine
249.12 eligibility under section 136A.121, subdivision 2, clause (5);

249.13 (14) participant Social Security numbers and names collected by the telephone assistance
249.14 program may be disclosed to the Department of Revenue to conduct an electronic data
249.15 match with the property tax refund database to determine eligibility under section 237.70,
249.16 subdivision 4a;

249.17 (15) the current address of a Minnesota family investment program participant may be
249.18 disclosed to law enforcement officers who provide the name of the participant and notify
249.19 the agency that:

249.20 (i) the participant:

249.21 (A) is a fugitive felon fleeing to avoid prosecution, or custody or confinement after
249.22 conviction, for a crime or attempt to commit a crime that is a felony under the laws of the
249.23 jurisdiction from which the individual is fleeing; or

249.24 (B) is violating a condition of probation or parole imposed under state or federal law;

249.25 (ii) the location or apprehension of the felon is within the law enforcement officer's
249.26 official duties; and

249.27 (iii) the request is made in writing and in the proper exercise of those duties;

249.28 (16) the current address of a recipient of general assistance may be disclosed to probation
249.29 officers and corrections agents who are supervising the recipient and to law enforcement
249.30 officers who are investigating the recipient in connection with a felony level offense;

249.31 (17) information obtained from food support applicant or recipient households may be
249.32 disclosed to local, state, or federal law enforcement officials, upon their written request, for

250.1 the purpose of investigating an alleged violation of the Food Stamp Act, according to Code
250.2 of Federal Regulations, title 7, section 272.1(c);

250.3 (18) the address, Social Security number, and, if available, photograph of any member
250.4 of a household receiving food support shall be made available, on request, to a local, state,
250.5 or federal law enforcement officer if the officer furnishes the agency with the name of the
250.6 member and notifies the agency that:

250.7 (i) the member:

250.8 (A) is fleeing to avoid prosecution, or custody or confinement after conviction, for a
250.9 crime or attempt to commit a crime that is a felony in the jurisdiction the member is fleeing;

250.10 (B) is violating a condition of probation or parole imposed under state or federal law;
250.11 or

250.12 (C) has information that is necessary for the officer to conduct an official duty related
250.13 to conduct described in subitem (A) or (B);

250.14 (ii) locating or apprehending the member is within the officer's official duties; and

250.15 (iii) the request is made in writing and in the proper exercise of the officer's official duty;

250.16 (19) the current address of a recipient of Minnesota family investment program, general
250.17 assistance, or food support may be disclosed to law enforcement officers who, in writing,
250.18 provide the name of the recipient and notify the agency that the recipient is a person required
250.19 to register under section 243.166, but is not residing at the address at which the recipient is
250.20 registered under section 243.166;

250.21 (20) certain information regarding child support obligors who are in arrears may be
250.22 made public according to section 518A.74;

250.23 (21) data on child support payments made by a child support obligor and data on the
250.24 distribution of those payments excluding identifying information on obligees may be
250.25 disclosed to all obligees to whom the obligor owes support, and data on the enforcement
250.26 actions undertaken by the public authority, the status of those actions, and data on the income
250.27 of the obligor or obligee may be disclosed to the other party;

250.28 (22) data in the work reporting system may be disclosed under section 256.998,
250.29 subdivision 7;

250.30 (23) to the Department of Education for the purpose of matching Department of Education
250.31 student data with public assistance data to determine students eligible for free and
250.32 reduced-price meals, meal supplements, and free milk according to United States Code,

251.1 title 42, sections 1758, 1761, 1766, 1766a, 1772, and 1773; to allocate federal and state
251.2 funds that are distributed based on income of the student's family; and to verify receipt of
251.3 energy assistance for the telephone assistance plan;

251.4 (24) the current address and telephone number of program recipients and emergency
251.5 contacts may be released to the commissioner of health or a community health board as
251.6 defined in section 145A.02, subdivision 5, when the commissioner or community health
251.7 board has reason to believe that a program recipient is a disease case, carrier, suspect case,
251.8 or at risk of illness, and the data are necessary to locate the person;

251.9 (25) to other state agencies, statewide systems, and political subdivisions of this state,
251.10 including the attorney general, and agencies of other states, interstate information networks,
251.11 federal agencies, and other entities as required by federal regulation or law for the
251.12 administration of the child support enforcement program;

251.13 (26) to personnel of public assistance programs as defined in section 256.741, for access
251.14 to the child support system database for the purpose of administration, including monitoring
251.15 and evaluation of those public assistance programs;

251.16 (27) to monitor and evaluate the Minnesota family investment program by exchanging
251.17 data between the Departments of Human Services and Education, on recipients and former
251.18 recipients of food support, cash assistance under chapter 256, 256D, 256J, or 256K, child
251.19 care assistance under chapter 119B, medical programs under chapter 256B or 256L, or a
251.20 medical program formerly codified under chapter 256D;

251.21 (28) to evaluate child support program performance and to identify and prevent fraud
251.22 in the child support program by exchanging data between the Department of Human Services,
251.23 Department of Revenue under section 270B.14, subdivision 1, paragraphs (a) and (b),
251.24 without regard to the limitation of use in paragraph (c), Department of Health, Department
251.25 of Employment and Economic Development, and other state agencies as is reasonably
251.26 necessary to perform these functions;

251.27 (29) counties operating child care assistance programs under chapter 119B may
251.28 disseminate data on program participants, applicants, and providers to the commissioner of
251.29 education;

251.30 (30) child support data on the child, the parents, and relatives of the child may be
251.31 disclosed to agencies administering programs under titles IV-B and IV-E of the Social
251.32 Security Act, as authorized by federal law; ~~or~~

252.1 (31) to a health care provider governed by sections 144.291 to 144.298, to the extent
252.2 necessary to coordinate services;

252.3 (32) to the chief administrative officer of a school to coordinate services for a student
252.4 and family; data that may be disclosed under this clause are limited to name, date of birth,
252.5 gender, and address; or

252.6 (33) to county correctional agencies to the extent necessary to coordinate services and
252.7 diversion programs; data that may be disclosed under this clause are limited to name, client
252.8 demographics, program, case status, and county worker information.

252.9 (b) Information on persons who have been treated for drug or alcohol abuse may only
252.10 be disclosed according to the requirements of Code of Federal Regulations, title 42, sections
252.11 2.1 to 2.67.

252.12 (c) Data provided to law enforcement agencies under paragraph (a), clause (15), (16),
252.13 (17), or (18), or paragraph (b), are investigative data and are confidential or protected
252.14 nonpublic while the investigation is active. The data are private after the investigation
252.15 becomes inactive under section 13.82, subdivision 5, paragraph (a) or (b).

252.16 (d) Mental health data shall be treated as provided in subdivisions 7, 8, and 9, but are
252.17 not subject to the access provisions of subdivision 10, paragraph (b).

252.18 For the purposes of this subdivision, a request will be deemed to be made in writing if
252.19 made through a computer interface system.

252.20 Sec. 4. Minnesota Statutes 2016, section 13.84, subdivision 5, is amended to read:

252.21 Subd. 5. **Disclosure.** Private or confidential court services data shall not be disclosed
252.22 except:

252.23 (a) pursuant to section 13.05;

252.24 (b) pursuant to a statute specifically authorizing disclosure of court services data;

252.25 (c) with the written permission of the source of confidential data;

252.26 (d) to the court services department, parole or probation authority or state or local
252.27 correctional agency or facility having statutorily granted supervision over the individual
252.28 subject of the data, or to county personnel within the welfare system;

252.29 (e) pursuant to subdivision 6;

252.30 (f) pursuant to a valid court order; or

252.31 (g) pursuant to section 611A.06, subdivision 3a.

253.1 Sec. 5. [119B.097] AUTHORIZATION WITH A SECONDARY PROVIDER.

253.2 (a) If a child uses any combination of the following providers paid by child care
 253.3 assistance, a parent must choose one primary provider and one secondary provider per child
 253.4 that can be paid by child care assistance:

253.5 (1) an individual or child care center licensed under chapter 245A;

253.6 (2) an individual or child care center or facility holding a valid child care license issued
 253.7 by another state or tribe; or

253.8 (3) a child care center exempt from licensing under section 245A.03.

253.9 (b) The amount of child care authorized with the secondary provider cannot exceed 20
 253.10 hours per two-week service period, per child, and the amount of care paid to a child's
 253.11 secondary provider is limited under section 119B.13, subdivision 1. The total amount of
 253.12 child care authorized with both the primary and secondary provider cannot exceed the
 253.13 amount of child care allowed based on the parents' eligible activity schedule, the child's
 253.14 school schedule, and any other factors relevant to the family's child care needs.

253.15 **EFFECTIVE DATE.** This section is effective April 23, 2018.

253.16 Sec. 6. Minnesota Statutes 2016, section 119B.13, subdivision 1, is amended to read:

253.17 Subdivision 1. **Subsidy restrictions.** (a) Beginning February 3, 2014, the maximum
 253.18 rate paid for child care assistance in any county or county price cluster under the child care
 253.19 fund shall be the greater of the 25th percentile of the 2011 child care provider rate survey
 253.20 or the maximum rate effective November 28, 2011. For a child care provider located within
 253.21 the boundaries of a city located in two or more of the counties of Benton, Sherburne, and
 253.22 Stearns, the maximum rate paid for child care assistance shall be equal to the maximum
 253.23 rate paid in the county with the highest maximum reimbursement rates or the provider's
 253.24 charge, whichever is less. The commissioner may: (1) assign a county with no reported
 253.25 provider prices to a similar price cluster; and (2) consider county level access when
 253.26 determining final price clusters.

253.27 (b) A rate which includes a special needs rate paid under subdivision 3 may be in excess
 253.28 of the maximum rate allowed under this subdivision.

253.29 (c) The department shall monitor the effect of this paragraph on provider rates. The
 253.30 county shall pay the provider's full charges for every child in care up to the maximum
 253.31 established. The commissioner shall determine the maximum rate for each type of care on
 253.32 an hourly, full-day, and weekly basis, including special needs and disability care.

254.1 ~~(d)~~ If a child uses one provider, the maximum payment ~~to a provider~~ for one day of care
 254.2 must not exceed the daily rate. The maximum payment ~~to a provider~~ for one week of care
 254.3 must not exceed the weekly rate.

254.4 (e) If a child uses two providers under section 119B.097, the maximum payment must
 254.5 not exceed:

254.6 (1) the daily rate for one day of care;

254.7 (2) the weekly rate for one week of care by the child's primary provider; and

254.8 (3) two daily rates during two weeks of care by a child's secondary provider.

254.9 ~~(d)~~ (f) Child care providers receiving reimbursement under this chapter must not be paid
 254.10 activity fees or an additional amount above the maximum rates for care provided during
 254.11 nonstandard hours for families receiving assistance.

254.12 ~~(e) When~~ (g) If the provider charge is greater than the maximum provider rate allowed,
 254.13 the parent is responsible for payment of the difference in the rates in addition to any family
 254.14 co-payment fee.

254.15 ~~(f)~~ (h) All maximum provider rates changes shall be implemented on the Monday
 254.16 following the effective date of the maximum provider rate.

254.17 ~~(g)~~ (i) Notwithstanding Minnesota Rules, part 3400.0130, subpart 7, maximum
 254.18 registration fees in effect on January 1, 2013, shall remain in effect.

254.19 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2018. Paragraphs (d) to (i) are
 254.20 effective April 23, 2018.

254.21 Sec. 7. Minnesota Statutes 2016, section 245.814, subdivision 2, is amended to read:

254.22 Subd. 2. **Application of coverage.** Coverage shall apply to all foster homes licensed by
 254.23 the Department of Human Services, licensed by a federally recognized tribal government,
 254.24 or established by the juvenile court and certified by the commissioner of corrections pursuant
 254.25 to section 260B.198, subdivision 1, clause (3), item (v), to the extent that the liability is not
 254.26 covered by the provisions of the standard homeowner's or automobile insurance policy. The
 254.27 insurance shall not cover ~~property owned by the individual foster home provider, damage~~
 254.28 ~~caused intentionally by a person over 12 years of age, or property damage arising out of~~
 254.29 ~~business pursuits or the operation of any vehicle, machinery, or equipment.~~

255.1 Sec. 8. Minnesota Statutes 2016, section 245.814, subdivision 3, is amended to read:

255.2 Subd. 3. **Compensation provisions.** If the commissioner of human services is unable
255.3 to obtain insurance through ordinary methods for coverage of foster home providers, the
255.4 appropriation shall be returned to the general fund and the state shall pay claims subject to
255.5 the following limitations.

255.6 (a) Compensation shall be provided only for injuries, damage, or actions set forth in
255.7 subdivision 1.

255.8 (b) Compensation shall be subject to the conditions and exclusions set forth in subdivision
255.9 2.

255.10 (c) The state shall provide compensation for bodily injury, property damage, or personal
255.11 injury resulting from the foster home providers activities as a foster home provider while
255.12 the foster child or adult is in the care, custody, and control of the foster home provider in
255.13 an amount not to exceed \$250,000 for each occurrence.

255.14 (d) The state shall provide compensation for damage or destruction of property caused
255.15 or sustained by a foster child or adult in an amount not to exceed ~~\$250~~ \$1,000 for each
255.16 occurrence.

255.17 (e) The compensation in paragraphs (c) and (d) is the total obligation for all damages
255.18 because of each occurrence regardless of the number of claims made in connection with
255.19 the same occurrence, but compensation applies separately to each foster home. The state
255.20 shall have no other responsibility to provide compensation for any injury or loss caused or
255.21 sustained by any foster home provider or foster child or foster adult.

255.22 This coverage is extended as a benefit to foster home providers to encourage care of
255.23 persons who need out-of-home care. Nothing in this section shall be construed to mean that
255.24 foster home providers are agents or employees of the state nor does the state accept any
255.25 responsibility for the selection, monitoring, supervision, or control of foster home providers
255.26 which is exclusively the responsibility of the counties which shall regulate foster home
255.27 providers in the manner set forth in the rules of the commissioner of human services.

255.28 Sec. 9. **[245A.23] EXEMPTION FROM POSITIVE SUPPORT STRATEGIES**
255.29 **REQUIREMENTS.**

255.30 (a) A program licensed as a family day care or group family day care facility under
255.31 Minnesota Rules, chapter 9502, and a program licensed as a child care center under
255.32 Minnesota Rules, chapter 9503, are exempt from Minnesota Rules, chapter 9544, relating
255.33 to positive support strategies and restrictive interventions.

256.1 (b) When providing services to a child with a developmental disability or related
256.2 condition, a program licensed as a family day care or group family day care facility under
256.3 Minnesota Rules, chapter 9502, or a program licensed as a child care center under Minnesota
256.4 Rules, chapter 9503, is prohibited from using procedures identified in section 245D.06,
256.5 subdivision 5.

256.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.

256.7 Sec. 10. Minnesota Statutes 2016, section 245A.50, subdivision 5, is amended to read:

256.8 Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a)
256.9 License holders must document that before staff persons, caregivers, and helpers assist in
256.10 the care of infants, they are instructed on the standards in section 245A.1435 and receive
256.11 training on reducing the risk of sudden unexpected infant death. In addition, license holders
256.12 must document that before staff persons, caregivers, and helpers assist in the care of infants
256.13 and children under school age, they receive training on reducing the risk of abusive head
256.14 trauma from shaking infants and young children. The training in this subdivision may be
256.15 provided as initial training under subdivision 1 or ongoing annual training under subdivision
256.16 7.

256.17 (b) Sudden unexpected infant death reduction training required under this subdivision
256.18 must, at a minimum, address the risk factors related to sudden unexpected infant death,
256.19 means of reducing the risk of sudden unexpected infant death in child care, and license
256.20 holder communication with parents regarding reducing the risk of sudden unexpected infant
256.21 death.

256.22 (c) Abusive head trauma training required under this subdivision must, at a minimum,
256.23 address the risk factors related to shaking infants and young children, means of reducing
256.24 the risk of abusive head trauma in child care, and license holder communication with parents
256.25 regarding reducing the risk of abusive head trauma.

256.26 (d) Training for family and group family child care providers must be developed by the
256.27 commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved
256.28 by the Minnesota Center for Professional Development. Sudden unexpected infant death
256.29 reduction training and abusive head trauma training may be provided in a single course of
256.30 no more than two hours in length.

256.31 (e) Sudden unexpected infant death reduction training and abusive head trauma training
256.32 required under this subdivision must be completed in person or as allowed under subdivision
256.33 10, clause (1) or (2), at least once every two years. On the years when the license holder is

257.1 not receiving training in person or as allowed under subdivision 10, clause (1) or (2), the
 257.2 license holder must receive sudden unexpected infant death reduction training and abusive
 257.3 head trauma training through a video of no more than one hour in length. The video must
 257.4 be developed or approved by the commissioner.

257.5 (f) An individual who is related to the license holder as defined in section 245A.02,
 257.6 subdivision 13, and who is involved only in the care of the license holder's own infant or
 257.7 child under school age and who is not designated to be a caregiver, helper, or substitute, as
 257.8 defined in Minnesota Rules, part 9502.0315, for the licensed program, is exempt from the
 257.9 sudden unexpected infant death and abusive head trauma training.

257.10 Sec. 11. Minnesota Statutes 2016, section 252.27, subdivision 2a, is amended to read:

257.11 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child,
 257.12 including a child determined eligible for medical assistance without consideration of parental
 257.13 income, must contribute to the cost of services used by making monthly payments on a
 257.14 sliding scale based on income, unless the child is married or has been married, parental
 257.15 rights have been terminated, or the child's adoption is subsidized according to chapter 259A
 257.16 or through title IV-E of the Social Security Act. The parental contribution is a partial or full
 257.17 payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating,
 257.18 rehabilitation, maintenance, and personal care services as defined in United States Code,
 257.19 title 26, section 213, needed by the child with a chronic illness or disability.

257.20 (b) For households with adjusted gross income equal to or greater than 275 percent of
 257.21 federal poverty guidelines, the parental contribution shall be computed by applying the
 257.22 following schedule of rates to the adjusted gross income of the natural or adoptive parents:

257.23 (1) if the adjusted gross income is equal to or greater than 275 percent of federal poverty
 257.24 guidelines and less than or equal to 545 percent of federal poverty guidelines, the parental
 257.25 contribution shall be determined using a sliding fee scale established by the commissioner
 257.26 of human services which begins at ~~2.23~~ 1.6725 percent of adjusted gross income at 275
 257.27 percent of federal poverty guidelines and increases to ~~6.08~~ 4.56 percent of adjusted gross
 257.28 income for those with adjusted gross income up to 545 percent of federal poverty guidelines;

257.29 (2) if the adjusted gross income is greater than 545 percent of federal poverty guidelines
 257.30 and less than 675 percent of federal poverty guidelines, the parental contribution shall be
 257.31 ~~6.08~~ 4.56 percent of adjusted gross income;

257.32 (3) if the adjusted gross income is equal to or greater than 675 percent of federal poverty
 257.33 guidelines and less than 975 percent of federal poverty guidelines, the parental contribution

258.1 shall be determined using a sliding fee scale established by the commissioner of human
258.2 services which begins at ~~6.08~~ 4.56 percent of adjusted gross income at 675 percent of federal
258.3 poverty guidelines and increases to ~~8.1~~ 6.075 percent of adjusted gross income for those
258.4 with adjusted gross income up to 975 percent of federal poverty guidelines; and

258.5 (4) if the adjusted gross income is equal to or greater than 975 percent of federal poverty
258.6 guidelines, the parental contribution shall be ~~10.13~~ 7.5975 percent of adjusted gross income.

258.7 If the child lives with the parent, the annual adjusted gross income is reduced by \$2,400
258.8 prior to calculating the parental contribution. If the child resides in an institution specified
258.9 in section 256B.35, the parent is responsible for the personal needs allowance specified
258.10 under that section in addition to the parental contribution determined under this section.
258.11 The parental contribution is reduced by any amount required to be paid directly to the child
258.12 pursuant to a court order, but only if actually paid.

258.13 (c) The household size to be used in determining the amount of contribution under
258.14 paragraph (b) includes natural and adoptive parents and their dependents, including the
258.15 child receiving services. Adjustments in the contribution amount due to annual changes in
258.16 the federal poverty guidelines shall be implemented on the first day of July following
258.17 publication of the changes.

258.18 (d) For purposes of paragraph (b), "income" means the adjusted gross income of the
258.19 natural or adoptive parents determined according to the previous year's federal tax form,
258.20 except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds
258.21 have been used to purchase a home shall not be counted as income.

258.22 (e) The contribution shall be explained in writing to the parents at the time eligibility
258.23 for services is being determined. The contribution shall be made on a monthly basis effective
258.24 with the first month in which the child receives services. Annually upon redetermination
258.25 or at termination of eligibility, if the contribution exceeded the cost of services provided,
258.26 the local agency or the state shall reimburse that excess amount to the parents, either by
258.27 direct reimbursement if the parent is no longer required to pay a contribution, or by a
258.28 reduction in or waiver of parental fees until the excess amount is exhausted. All
258.29 reimbursements must include a notice that the amount reimbursed may be taxable income
258.30 if the parent paid for the parent's fees through an employer's health care flexible spending
258.31 account under the Internal Revenue Code, section 125, and that the parent is responsible
258.32 for paying the taxes owed on the amount reimbursed.

258.33 (f) The monthly contribution amount must be reviewed at least every 12 months; when
258.34 there is a change in household size; and when there is a loss of or gain in income from one

259.1 month to another in excess of ten percent. The local agency shall mail a written notice 30
259.2 days in advance of the effective date of a change in the contribution amount. A decrease in
259.3 the contribution amount is effective in the month that the parent verifies a reduction in
259.4 income or change in household size.

259.5 (g) Parents of a minor child who do not live with each other shall each pay the
259.6 contribution required under paragraph (a). An amount equal to the annual court-ordered
259.7 child support payment actually paid on behalf of the child receiving services shall be deducted
259.8 from the adjusted gross income of the parent making the payment prior to calculating the
259.9 parental contribution under paragraph (b).

259.10 (h) The contribution under paragraph (b) shall be increased by an additional five percent
259.11 if the local agency determines that insurance coverage is available but not obtained for the
259.12 child. For purposes of this section, "available" means the insurance is a benefit of employment
259.13 for a family member at an annual cost of no more than five percent of the family's annual
259.14 income. For purposes of this section, "insurance" means health and accident insurance
259.15 coverage, enrollment in a nonprofit health service plan, health maintenance organization,
259.16 self-insured plan, or preferred provider organization.

259.17 Parents who have more than one child receiving services shall not be required to pay
259.18 more than the amount for the child with the highest expenditures. There shall be no resource
259.19 contribution from the parents. The parent shall not be required to pay a contribution in
259.20 excess of the cost of the services provided to the child, not counting payments made to
259.21 school districts for education-related services. Notice of an increase in fee payment must
259.22 be given at least 30 days before the increased fee is due.

259.23 (i) The contribution under paragraph (b) shall be reduced by \$300 per fiscal year if, in
259.24 the 12 months prior to July 1:

259.25 (1) the parent applied for insurance for the child;

259.26 (2) the insurer denied insurance;

259.27 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a
259.28 complaint or appeal, in writing, to the commissioner of health or the commissioner of
259.29 commerce, or litigated the complaint or appeal; and

259.30 (4) as a result of the dispute, the insurer reversed its decision and granted insurance.

259.31 For purposes of this section, "insurance" has the meaning given in paragraph (h).

259.32 A parent who has requested a reduction in the contribution amount under this paragraph
259.33 shall submit proof in the form and manner prescribed by the commissioner or county agency,

260.1 including, but not limited to, the insurer's denial of insurance, the written letter or complaint
 260.2 of the parents, court documents, and the written response of the insurer approving insurance.
 260.3 The determinations of the commissioner or county agency under this paragraph are not rules
 260.4 subject to chapter 14.

260.5 Sec. 12. Minnesota Statutes 2016, section 256E.30, subdivision 2, is amended to read:

260.6 Subd. 2. **Allocation of money.** (a) State money appropriated and community service
 260.7 block grant money allotted to the state and all money transferred to the community service
 260.8 block grant from other block grants shall be allocated annually to community action agencies
 260.9 and Indian reservation governments under clauses (b) and (c), and to migrant and seasonal
 260.10 farmworker organizations under clause (d).

260.11 (b) The available annual money will provide base funding to all community action
 260.12 agencies and the Indian reservations. Base funding amounts per agency are as follows: for
 260.13 agencies with low income populations up to ~~3,999~~ 1,999, \$25,000; ~~4,000~~ 2,000 to 23,999,
 260.14 \$50,000; and 24,000 or more, \$100,000.

260.15 (c) All remaining money of the annual money available after the base funding has been
 260.16 determined must be allocated to each agency and reservation in proportion to the size of
 260.17 the poverty level population in the agency's service area compared to the size of the poverty
 260.18 level population in the state.

260.19 (d) Allocation of money to migrant and seasonal farmworker organizations must not
 260.20 exceed three percent of the total annual money available. Base funding allocations must be
 260.21 made for all community action agencies and Indian reservations that received money under
 260.22 this subdivision, in fiscal year 1984, and for community action agencies designated under
 260.23 this section with a service area population of 35,000 or greater.

260.24 Sec. 13. Minnesota Statutes 2016, section 256J.24, subdivision 5, is amended to read:

260.25 Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based on the
 260.26 number of persons in the assistance unit eligible for both food and cash assistance. The
 260.27 amount of the transitional standard is published annually by the Department of Human
 260.28 Services. The following table represents the cash portion of the transitional standard effective
 260.29 March 1, 2018.

260.30	<u>Number of eligible people</u>	<u>Cash portion</u>
260.31	<u>1</u>	<u>\$263</u>
260.32	<u>2</u>	<u>\$450</u>
260.33	<u>3</u>	<u>\$545</u>

261.1	<u>4</u>	<u>\$634</u>
261.2	<u>5</u>	<u>\$710</u>
261.3	<u>6</u>	<u>\$786</u>
261.4	<u>7</u>	<u>\$863</u>
261.5	<u>8</u>	<u>\$929</u>
261.6	<u>9</u>	<u>\$993</u>
261.7	<u>10</u>	<u>\$1,048</u>
261.8	<u>Over 10</u>	<u>add \$56 for each additional eligible person</u>

261.9 Sec. 14. Minnesota Statutes 2016, section 256J.45, subdivision 2, is amended to read:

261.10 Subd. 2. **General information.** The MFIP orientation must consist of a presentation
261.11 that informs caregivers of:

261.12 (1) the necessity to obtain immediate employment;

261.13 (2) the work incentives under MFIP, including the availability of the federal earned
261.14 income tax credit and the Minnesota working family tax credit;

261.15 (3) the requirement to comply with the employment plan and other requirements of the
261.16 employment and training services component of MFIP, including a description of the range
261.17 of work and training activities that are allowable under MFIP to meet the individual needs
261.18 of participants;

261.19 (4) the consequences for failing to comply with the employment plan and other program
261.20 requirements, and that the county agency may not impose a sanction when failure to comply
261.21 is due to the unavailability of child care or other circumstances where the participant has
261.22 good cause under subdivision 3;

261.23 (5) the rights, responsibilities, and obligations of participants;

261.24 (6) the types and locations of child care services available through the county agency;

261.25 (7) the availability and the benefits of the early childhood health and developmental
261.26 screening under sections 121A.16 to 121A.19; 123B.02, subdivision 16; and 123B.10;

261.27 (8) the caregiver's eligibility for transition year child care assistance under section
261.28 119B.05;

261.29 (9) the availability of all health care programs, including transitional medical assistance;

261.30 (10) the caregiver's option to choose an employment and training provider and information
261.31 about each provider, including but not limited to, services offered, program components,
261.32 job placement rates, job placement wages, and job retention rates;

262.1 (11) the caregiver's option to request approval of an education and training plan according
 262.2 to section 256J.53;

262.3 (12) the work study programs available under the higher education system; ~~and~~

262.4 (13) information about the 60-month time limit exemptions under the family violence
 262.5 waiver and referral information about shelters and programs for victims of family violence;
 262.6 and

262.7 (14) information about the income exclusions under section 256P.06, subdivision 2.

262.8 **EFFECTIVE DATE.** This section is effective December 1, 2018.

262.9 Sec. 15. [256N.261] **SUPPORT FOR ADOPTIVE, FOSTER, AND KINSHIP**
 262.10 **FAMILIES.**

262.11 Subdivision 1. **Program established.** The commissioner shall design and implement a
 262.12 coordinated program to reduce the need for placement changes or out-of-home placements
 262.13 of children and youth in foster care, adoptive placements, and permanent physical and legal
 262.14 custody kinship placements, and to improve the functioning and stability of these families.
 262.15 To the extent federal funds are available, the commissioner shall provide the following
 262.16 adoption and foster care-competent services and ensure that placements are trauma-informed
 262.17 and child and family-centered:

262.18 (1) a program providing information, referrals, a parent-to-parent support network, peer
 262.19 support for youth, family activities, respite care, crisis services, educational support, and
 262.20 mental health services for children and youth in adoption, foster care, and kinship placements
 262.21 and adoptive, foster, and kinship families in Minnesota;

262.22 (2) training offered statewide in Minnesota for adoptive and kinship families, and training
 262.23 for foster families, and the professionals who serve the families, on the effects of trauma,
 262.24 common disabilities of adopted children and children in foster care, and kinship placements,
 262.25 and challenges in adoption, foster care, and kinship placements; and

262.26 (3) periodic evaluation of these services to ensure program effectiveness in preserving
 262.27 and improving the success of adoptive, foster, and kinship placements.

262.28 Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

262.29 (b) "Child and family-centered" means individualized services that respond to a child's
 262.30 or youth's strengths, interests, and current developmental stage, including social, cognitive,
 262.31 emotional, physical, cultural, racial, and spiritual needs, and offer support to the entire
 262.32 adoptive, foster, or kinship family.

263.1 (c) "Trauma-informed" means care that acknowledges the effect trauma has on children
263.2 and the children's families; modifies services to respond to the effects of trauma; emphasizes
263.3 skill and strength-building rather than symptom management; and focuses on the physical
263.4 and psychological safety of the child and family.

263.5 Sec. 16. Minnesota Statutes 2016, section 256P.06, subdivision 2, is amended to read:

263.6 Subd. 2. **Exempted individuals.** (a) The following members of an assistance unit under
263.7 chapters 119B and 256J are exempt from having their earned income count towards the
263.8 income of an assistance unit:

263.9 (1) children under six years old;

263.10 (2) caregivers under 20 years of age enrolled at least half-time in school; and

263.11 (3) minors enrolled in school full time.

263.12 (b) The following members of an assistance unit are exempt from having their earned
263.13 and unearned income count towards the income of an assistance unit for 12 consecutive
263.14 calendar months, beginning the month following the marriage date, for benefits under chapter
263.15 256J if the household income does not exceed 275 percent of the federal poverty guideline:

263.16 (1) a new spouse to a caretaker in an existing assistance unit; and

263.17 (2) the spouse designated by a newly married couple, both of whom were already
263.18 members of an assistance unit under chapter 256J.

263.19 (c) If members identified in paragraph (b) also receive assistance under section 119B.05,
263.20 they are exempt from having their earned and unearned income count towards the income
263.21 of the assistance unit if the household income prior to the exemption does not exceed 67
263.22 percent of the state median income for recipients for 26 consecutive biweekly periods
263.23 beginning the second biweekly period after the marriage date.

263.24 **EFFECTIVE DATE.** This section is effective December 1, 2018.

263.25 Sec. 17. Minnesota Statutes 2016, section 260C.451, subdivision 6, is amended to read:

263.26 Subd. 6. **Reentering foster care and accessing services after 18 years of age and up**
263.27 **to 21 years of age.** (a) Upon request of an individual who had been under the guardianship
263.28 of the commissioner and who has left foster care without being adopted, the responsible
263.29 social services agency which had been the commissioner's agent for purposes of the
263.30 guardianship shall develop with the individual a plan to increase the individual's ability to
263.31 live safely and independently using the plan requirements of section 260C.212, subdivision

264.1 1, paragraph (c), clause (12), and to assist the individual to meet one or more of the eligibility
264.2 criteria in subdivision 4 if the individual wants to reenter foster care. The responsible social
264.3 services agency shall provide foster care as required to implement the plan. The responsible
264.4 social services agency shall enter into a voluntary placement agreement under section
264.5 260C.229 with the individual if the plan includes foster care.

264.6 (b) Individuals who had not been under the guardianship of the commissioner of human
264.7 services prior to 18 years of age may ask to reenter foster care after age 18 and, ~~to the extent~~
264.8 ~~funds are available~~, the responsible social services agency that had responsibility for planning
264.9 for the individual before discharge from foster care ~~may~~ shall provide foster care or other
264.10 services to the individual for the purpose of increasing the individual's ability to live safely
264.11 and independently and to meet the eligibility criteria in subdivision 3a, if the individual:

264.12 (1) was in foster care for the six consecutive months prior to the person's 18th birthday,
264.13 or left foster care within six months prior to the person's 18th birthday, and was not
264.14 discharged home, adopted, or received into a relative's home under a transfer of permanent
264.15 legal and physical custody under section 260C.515, subdivision 4; or

264.16 (2) was discharged from foster care while on runaway status after age 15.

264.17 (c) In conjunction with a qualifying and eligible individual under paragraph (b) and
264.18 other appropriate persons, the responsible social services agency shall develop a specific
264.19 plan related to that individual's vocational, educational, social, or maturational needs and,
264.20 ~~to the extent funds are available~~, provide foster care as required to implement the plan. The
264.21 responsible social services agency shall enter into a voluntary placement agreement with
264.22 the individual if the plan includes foster care.

264.23 (d) A child who left foster care while under guardianship of the commissioner of human
264.24 services retains eligibility for foster care for placement at any time prior to 21 years of age.

264.25 Sec. 18. **MINNESOTA BIRTH TO AGE EIGHT PILOT PROJECT.**

264.26 Subdivision 1. Authorization. The commissioner of human services shall award a grant
264.27 to Dakota County to develop and implement pilots that will evaluate the impact of a
264.28 coordinated systems and service delivery approach on key developmental milestones and
264.29 outcomes that ultimately lead to reading proficiency by age eight within the target population.
264.30 The pilot program is from July 1, 2017, to June 30, 2021.

264.31 Subd. 2. Pilot design and goals. The pilot will establish five key developmental milestone
264.32 markers from birth to age eight. Enrollees in the pilot will be developmentally assessed and
264.33 tracked by a technology solution that tracks developmental milestones along the established

265.1 developmental continuum. If a child's progress falls below established milestones and the
 265.2 weighted scoring, the coordinated service system will focus on identified areas of concern,
 265.3 mobilize appropriate supportive services, and offer services to identified children and their
 265.4 families.

265.5 Subd. 3. **Program participants in phase 1 target population.** Pilot program participants
 265.6 must:

265.7 (1) be enrolled in a Women's Infant & Children (WIC) program;

265.8 (2) be participating in a family home visiting program, or nurse family practice, or
 265.9 Healthy Families America (HFA);

265.10 (3) be children and families qualifying for and participating in early language learners
 265.11 (ELL) in the school district in which they reside; and

265.12 (4) opt-in and provide parental consent to participate in the pilot project.

265.13 Subd. 4. **Evaluation and report.** The county or counties shall work with a third-party
 265.14 evaluator to evaluate the effectiveness of the pilot and report to the legislative committees
 265.15 with jurisdiction over human services policy and finance each year by February 1 with an
 265.16 update on the progress of the pilot. The final report on the pilot is due January 1, 2022.

265.17 Sec. 19. **MINNESOTA PATHWAYS TO PROSPERITY PILOT PROJECT.**

265.18 Subdivision 1. **Authorization.** The commissioner of human services may develop a
 265.19 pilot project that shall test an alternative financing model for the distribution of publicly
 265.20 funded benefits. The commissioner may work with interested counties to develop the pilot
 265.21 and determine the waivers that are necessary to implement the pilot project based on the
 265.22 pilot design in subdivisions 2 and 3, and outcome measures in subdivision 4.

265.23 Subd. 2. **Pilot project goals.** The goals of the pilot project are to:

265.24 (1) reduce the historical separation among the state programs and systems affecting
 265.25 families who are receiving public assistance;

265.26 (2) eliminate, where possible, funding restrictions to allow a more comprehensive
 265.27 approach to the needs of the families in the pilot project; and

265.28 (3) focus on upstream, prevention-oriented supports and interventions.

265.29 Subd. 3. **Project participants.** The pilot project developed by the commissioner may
 265.30 include requirements that participants:

265.31 (1) be 26 years of age or younger with a minimum of one child;

266.1 (2) voluntarily agree to participate in the pilot project;

266.2 (3) be eligible for, applying for, or receiving public benefits including but not limited
 266.3 to housing assistance, education supports, employment supports, child care, transportation
 266.4 supports, medical assistance, earned income tax credit, or the child care tax credit; and

266.5 (4) be enrolled in an education program that is focused on obtaining a career that will
 266.6 likely result in a livable wage.

266.7 Subd. 4. **Outcomes.** The outcome measures for the pilot project must include:

266.8 (1) improvement in the affordability, safety, and permanence of suitable housing;

266.9 (2) improvement in family functioning and stability, including in the areas of behavioral
 266.10 health, incarceration, involvement with the child welfare system, or equivalent indicators;

266.11 (3) improvement in education readiness and outcomes for parents and children from
 266.12 early childhood through high school, including reduction in absenteeism, preschool readiness
 266.13 scores, third grade reading competency, graduation, GPA, and standardized test improvement;

266.14 (4) improvement in attachment to the workforce of one or both parents, including
 266.15 enhanced job stability; wage gains; career advancement; progress in career preparation; or
 266.16 an equivalent combination of these or related measures; and

266.17 (5) improvement in health care access and health outcomes for parents and children.

266.18 **Sec. 20. INDIAN CHILD WELFARE ACT COMPLIANCE SYSTEM REVIEW.**

266.19 By February 1, 2018, the commissioner of human services shall report back to the
 266.20 legislature on a system for the review of cases reported by counties for aid payments under
 266.21 Minnesota Statutes, section 477A.0126, for compliance with the Indian Child Welfare Act
 266.22 and the Minnesota Indian Family Preservation Act. The proposed case review system may
 266.23 include, but is not limited to, the cases to be reviewed, the criteria to be reviewed to
 266.24 demonstrate compliance with the Indian Child Welfare Act and the Minnesota Indian Family
 266.25 Preservation Act, the rate of noncompliance, and training.

266.26 **Sec. 21. MOBILE FOOD SHELF GRANTS.**

266.27 Subdivision 1. **Grant amount.** Hunger Solutions shall award grants on a priority basis
 266.28 under subdivision 3. A grant to sustain an existing mobile program shall not exceed \$25,000.
 266.29 A grant to create a new mobile program shall not exceed \$75,000.

266.30 Subd. 2. **Application contents.** An applicant for a grant under this section must provide
 266.31 the following information to Hunger Solutions:

- 267.1 (1) the location of the project;
- 267.2 (2) a description of the mobile program, including the program's size and scope;
- 267.3 (3) evidence regarding the unserved or underserved nature of the community in which
- 267.4 the project is to be located;
- 267.5 (4) evidence of community support for the project;
- 267.6 (5) the total cost of the project;
- 267.7 (6) the amount of the grant request and how funds will be used;
- 267.8 (7) sources of funding or in-kind contributions for the project that may supplement any
- 267.9 grant award;
- 267.10 (8) the applicant's commitment to maintain the mobile program; and
- 267.11 (9) any additional information requested by Hunger Solutions.
- 267.12 Subd. 3. **Awarding grants.** In evaluating applications and awarding grants, Hunger
- 267.13 Solutions must give priority to an applicant who:
- 267.14 (1) serves unserved or underserved areas;
- 267.15 (2) creates a new mobile program or expands an existing mobile program;
- 267.16 (3) serves areas where a high level of need is identified;
- 267.17 (4) provides evidence of strong support for the project from residents and other institutions
- 267.18 in the community;
- 267.19 (5) leverages funding for the project from other private and public sources; and
- 267.20 (6) commits to maintaining the program on a multiyear basis.
- 267.21 **Sec. 22. CHILD CARE CORRECTION ORDER POSTING GUIDELINES.**
- 267.22 No later than November 1, 2017, the commissioner shall develop guidelines for posting
- 267.23 public licensing data for licensed child care programs. In developing the guidelines, the
- 267.24 commissioner shall consult with stakeholders, including licensed child care center providers,
- 267.25 family child care providers, and county agencies.
- 267.26 **Sec. 23. REPEALER.**
- 267.27 Minnesota Statutes 2016, sections 13.468; 179A.50; 179A.51; 179A.52; 179A.53; and
- 267.28 256J.626, subdivision 5, are repealed.

ARTICLE 8

CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. [245.4662] GRANT PROGRAM; MENTAL HEALTH INNOVATION.

Subdivision 1. Definitions. (a) For purposes of this section, the following terms have the meanings given them.

(b) "Community partnership" means a project involving the collaboration of two or more eligible applicants.

(c) "Eligible applicant" means an eligible county, Indian tribe, mental health service provider, hospital, or community partnership. Eligible applicant does not include a state-operated direct care and treatment facility or program under chapter 246.

(d) "Intensive residential treatment services" has the meaning given in section 256B.0622, subdivision 2.

(e) "Metropolitan area" means the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Subd. 2. Grants authorized. The commissioner of human services shall, in consultation with stakeholders, award grants to eligible applicants to plan, establish, or operate programs to improve accessibility and quality of community-based, outpatient mental health services and reduce the number of clients admitted to regional treatment centers and community behavioral health hospitals. This is a onetime appropriation that is available until June 30, 2021. The commissioner shall award half of all grant funds to eligible applicants in the metropolitan area and half of all grant funds to eligible applicants outside the metropolitan area. An applicant may apply for and the commissioner may award grants for two-year periods.

Subd. 3. Allocation of grants. (a) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:

(1) a description of the purpose or project for which grant funds will be used;

(2) a description of the specific problem the grant funds will address;

(3) a letter of support from the local mental health authority;

(4) a description of achievable objectives, a work plan, and a timeline for implementation and completion of processes or projects enabled by the grant; and

(5) a process for documenting and evaluating results of the grant.

269.1 (b) The commissioner shall review each application to determine whether the application
269.2 is complete and whether the applicant and the project are eligible for a grant. In evaluating
269.3 applications according to paragraph (c), the commissioner shall establish criteria including,
269.4 but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in
269.5 describing the problem grant funds are intended to address; a description of the applicant's
269.6 proposed project; a description of the population demographics and service area of the
269.7 proposed project; the manner in which the applicant will demonstrate the effectiveness of
269.8 any projects undertaken; the proposed project's longevity and demonstrated financial
269.9 sustainability after the initial grant period; and evidence of efficiencies and effectiveness
269.10 gained through collaborative efforts. The commissioner may also consider other relevant
269.11 factors. In evaluating applications, the commissioner may request additional information
269.12 regarding a proposed project, including information on project cost. An applicant's failure
269.13 to provide the information requested disqualifies an applicant. The commissioner shall
269.14 determine the number of grants awarded.

269.15 (c) Eligible applicants may receive grants under this section for purposes including, but
269.16 not limited to, the following:

269.17 (1) intensive residential treatment services providing time-limited mental health services
269.18 in a residential setting;

269.19 (2) the creation of stand-alone urgent care centers for mental health and psychiatric
269.20 consultation services, crisis residential services, or collaboration between crisis teams and
269.21 critical access hospitals;

269.22 (3) establishing new community mental health services or expanding the capacity of
269.23 existing services, including supportive housing; and

269.24 (4) other innovative projects that improve options for mental health services in community
269.25 settings and reduce the number of clients who remain in regional treatment centers and
269.26 community behavioral health hospitals beyond when discharge is determined to be clinically
269.27 appropriate.

269.28 Subd. 4. **Report to legislature.** By December 1, 2019, the commissioner of human
269.29 services shall deliver a report to the chairs and ranking minority members of the legislative
269.30 committees with jurisdiction over mental health issues on the outcomes of the projects
269.31 funded under this section. The report shall, at a minimum, include the amount of funding
269.32 awarded for each project, a description of the programs and services funded, plans for the
269.33 long-term sustainability of the projects, and data on outcomes for the programs and services

270.1 funded. Grantees must provide information and data requested by the commissioner to
270.2 support the development of this report.

270.3 Sec. 2. Minnesota Statutes 2016, section 245.4889, subdivision 1, is amended to read:

270.4 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to
270.5 make grants from available appropriations to assist:

270.6 (1) counties;

270.7 (2) Indian tribes;

270.8 (3) children's collaboratives under section 124D.23 or 245.493; or

270.9 (4) mental health service providers.

270.10 (b) The following services are eligible for grants under this section:

270.11 (1) services to children with emotional disturbances as defined in section 245.4871,
270.12 subdivision 15, and their families;

270.13 (2) transition services under section 245.4875, subdivision 8, for young adults under
270.14 age 21 and their families;

270.15 (3) respite care services for children with severe emotional disturbances who are at risk
270.16 of out-of-home placement;

270.17 (4) children's mental health crisis services;

270.18 (5) mental health services for people from cultural and ethnic minorities;

270.19 (6) children's mental health screening and follow-up diagnostic assessment and treatment;

270.20 (7) services to promote and develop the capacity of providers to use evidence-based
270.21 practices in providing children's mental health services;

270.22 (8) school-linked mental health services, including transportation for children receiving
270.23 school-linked mental health services when school is not in session;

270.24 (9) building evidence-based mental health intervention capacity for children birth to age
270.25 five;

270.26 (10) suicide prevention and counseling services that use text messaging statewide;

270.27 (11) mental health first aid training;

271.1 (12) training for parents, collaborative partners, and mental health providers on the
 271.2 impact of adverse childhood experiences and trauma and development of an interactive
 271.3 Web site to share information and strategies to promote resilience and prevent trauma;

271.4 (13) transition age services to develop or expand mental health treatment and supports
 271.5 for adolescents and young adults 26 years of age or younger;

271.6 (14) early childhood mental health consultation;

271.7 (15) evidence-based interventions for youth at risk of developing or experiencing a first
 271.8 episode of psychosis, and a public awareness campaign on the signs and symptoms of
 271.9 psychosis; ~~and~~

271.10 (16) psychiatric consultation for primary care practitioners; and

271.11 (17) providers to begin operations and meet program requirements when establishing a
 271.12 new children's mental health program. These may be start-up grants.

271.13 (c) Services under paragraph (b) must be designed to help each child to function and
 271.14 remain with the child's family in the community and delivered consistent with the child's
 271.15 treatment plan. Transition services to eligible young adults under this paragraph ~~(b)~~ must
 271.16 be designed to foster independent living in the community.

271.17 **EFFECTIVE DATE.** Clause (17) is effective the day following final enactment.

271.18 Sec. 3. Minnesota Statutes 2016, section 245.91, subdivision 4, is amended to read:

271.19 Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or
 271.20 residential program as defined in section 245A.02, subdivisions 10 and 14, ~~that is required~~
 271.21 ~~to be licensed by the commissioner of human services, and any agency, facility, or program~~
 271.22 that provides services or treatment for mental illness, developmental disabilities, chemical
 271.23 dependency, or emotional disturbance that is required to be licensed, certified, or registered
 271.24 by the commissioner of human services, health, or education; and an acute care inpatient
 271.25 facility that provides services or treatment for mental illness, developmental disabilities,
 271.26 chemical dependency, or emotional disturbance.

271.27 **EFFECTIVE DATE.** This section is effective the day following final enactment.

271.28 Sec. 4. Minnesota Statutes 2016, section 245.91, subdivision 6, is amended to read:

271.29 Subd. 6. **Serious injury.** "Serious injury" means:

271.30 (1) fractures;

- 272.1 (2) dislocations;
- 272.2 (3) evidence of internal injuries;
- 272.3 (4) head injuries with loss of consciousness or potential for a closed head injury or
- 272.4 concussion without loss of consciousness requiring a medical assessment by a health care
- 272.5 professional, whether or not further medical attention was sought;
- 272.6 (5) lacerations involving injuries to tendons or organs, and those for which complications
- 272.7 are present;
- 272.8 (6) extensive second-degree or third-degree burns, and other burns for which
- 272.9 complications are present;
- 272.10 (7) extensive second-degree or third-degree frostbite, and others for which complications
- 272.11 are present;
- 272.12 (8) irreversible mobility or avulsion of teeth;
- 272.13 (9) injuries to the eyeball;
- 272.14 (10) ingestion of foreign substances and objects that are harmful;
- 272.15 (11) near drowning;
- 272.16 (12) heat exhaustion or sunstroke; ~~and~~
- 272.17 (13) attempted suicide; and
- 272.18 (14) all other injuries and incidents considered serious after an assessment by a physician
- 272.19 health care professional, including but not limited to self-injurious behavior, a medication
- 272.20 error requiring medical treatment, a suspected delay of medical treatment, a complication
- 272.21 of a previous injury, or a complication of medical treatment for an injury.

272.22 **EFFECTIVE DATE.** This section is effective the day following final enactment.

272.23 Sec. 5. Minnesota Statutes 2016, section 245.94, subdivision 1, is amended to read:

272.24 Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which

272.25 complaints to the office are to be made, reviewed, and acted upon. The ombudsman may

272.26 not levy a complaint fee.

272.27 (b) The ombudsman is a health oversight agency as defined in Code of Federal

272.28 Regulations, title 45, section 164.501. The ombudsman may access patient records according

272.29 to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph,

273.1 "records" has the meaning given in Code of Federal Regulations, title 42, section
 273.2 2.53(a)(1)(i).

273.3 (c) The ombudsman may mediate or advocate on behalf of a client.

273.4 ~~(e)~~ (d) The ombudsman may investigate the quality of services provided to clients and
 273.5 determine the extent to which quality assurance mechanisms within state and county
 273.6 government work to promote the health, safety, and welfare of clients, ~~other than clients in~~
 273.7 ~~acute care facilities who are receiving services not paid for by public funds. The ombudsman~~
 273.8 ~~is a health oversight agency as defined in Code of Federal Regulations, title 45, section~~
 273.9 ~~164.501.~~

273.10 ~~(d)~~ (e) At the request of a client, or upon receiving a complaint or other information
 273.11 affording reasonable grounds to believe that the rights of ~~a client~~ one or more clients who
 273.12 ~~is~~ may not be capable of requesting assistance have been adversely affected, the ombudsman
 273.13 may gather information and data about and analyze, on behalf of the client, the actions of
 273.14 an agency, facility, or program.

273.15 ~~(e)~~ (f) The ombudsman may gather, on behalf of ~~a client~~ one or more clients, records of
 273.16 an agency, facility, or program, or records related to clinical drug trials from the University
 273.17 of Minnesota Department of Psychiatry, if the records relate to a matter that is within the
 273.18 scope of the ombudsman's authority. If the records are private and the client is capable of
 273.19 providing consent, the ombudsman shall first obtain the client's consent. The ombudsman
 273.20 is not required to obtain consent for access to private data on clients with developmental
 273.21 disabilities and individuals served by the Minnesota sex offender program. The ombudsman
 273.22 may also take photographic or videographic evidence while reviewing the actions of an
 273.23 agency, facility, or program, with the consent of the client. The ombudsman is not required
 273.24 to obtain consent for access to private data on decedents who were receiving services for
 273.25 mental illness, developmental disabilities, chemical dependency, or emotional disturbance.
 273.26 All data collected, created, received, or maintained by the ombudsman are governed by
 273.27 chapter 13 and other applicable law.

273.28 ~~(f)~~ (g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person
 273.29 to appear, give testimony, or produce documents or other evidence that the ombudsman
 273.30 considers relevant to a matter under inquiry. The ombudsman may petition the appropriate
 273.31 court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part
 273.32 of an investigation possesses the same privileges that a witness possesses in the courts or
 273.33 under the law of this state. Data obtained from a person under this paragraph are private
 273.34 data as defined in section 13.02, subdivision 12.

274.1 ~~(g)~~ (h) The ombudsman may, at reasonable times in the course of conducting a review,
 274.2 enter and view premises within the control of an agency, facility, or program.

274.3 ~~(h)~~ (i) The ombudsman may attend Department of Human Services Review Board and
 274.4 Special Review Board proceedings; proceedings regarding the transfer of clients, as defined
 274.5 in section 246.50, subdivision 4, between institutions operated by the Department of Human
 274.6 Services; and, subject to the consent of the affected client, other proceedings affecting the
 274.7 rights of clients. The ombudsman is not required to obtain consent to attend meetings or
 274.8 proceedings and have access to private data on clients with developmental disabilities and
 274.9 individuals served by the Minnesota sex offender program.

274.10 ~~(i)~~ (j) The ombudsman shall gather data of agencies, facilities, or programs classified
 274.11 as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding
 274.12 services provided to clients with developmental disabilities and individuals served by the
 274.13 Minnesota sex offender program.

274.14 ~~(j)~~ (k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant
 274.15 licensing or regulatory officials before undertaking a review of an action of the facility or
 274.16 program.

274.17 (l) The Office of Ombudsman shall provide the services of the Civil Commitment
 274.18 Training and Resource Center.

274.19 ~~(k)~~ (m) The ombudsman shall monitor the treatment of individuals participating in a
 274.20 University of Minnesota Department of Psychiatry clinical drug trial and ensure that all
 274.21 protections for human subjects required by federal law and the Institutional Review Board
 274.22 are provided.

274.23 ~~(l)~~ (n) Sections 245.91 to 245.97 are in addition to other provisions of law under which
 274.24 any other remedy or right is provided.

274.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

274.26 Sec. 6. Minnesota Statutes 2016, section 245.97, subdivision 6, is amended to read:

274.27 Subd. 6. **Terms, compensation, and removal.** The membership terms, compensation,
 274.28 and removal of members of the committee and the filling of membership vacancies are
 274.29 governed by section ~~15.0575~~ 15.0597.

274.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.

275.1 Sec. 7. Minnesota Statutes 2016, section 245A.03, subdivision 2, is amended to read:

275.2 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

275.3 (1) residential or nonresidential programs that are provided to a person by an individual
275.4 who is related unless the residential program is a child foster care placement made by a
275.5 local social services agency or a licensed child-placing agency, except as provided in
275.6 subdivision 2a;

275.7 (2) nonresidential programs that are provided by an unrelated individual to persons from
275.8 a single related family;

275.9 (3) residential or nonresidential programs that are provided to adults who do not ~~abuse~~
275.10 ~~chemicals or who do not have a chemical dependency~~ misuse substances or have a substance
275.11 use disorder, a mental illness, a developmental disability, a functional impairment, or a
275.12 physical disability;

275.13 (4) sheltered workshops or work activity programs that are certified by the commissioner
275.14 of employment and economic development;

275.15 (5) programs operated by a public school for children 33 months or older;

275.16 (6) nonresidential programs primarily for children that provide care or supervision for
275.17 periods of less than three hours a day while the child's parent or legal guardian is in the
275.18 same building as the nonresidential program or present within another building that is
275.19 directly contiguous to the building in which the nonresidential program is located;

275.20 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
275.21 under section 245A.02;

275.22 (8) board and lodge facilities licensed by the commissioner of health that do not provide
275.23 children's residential services under Minnesota Rules, chapter 2960, mental health or chemical
275.24 dependency treatment;

275.25 (9) homes providing programs for persons placed by a county or a licensed agency for
275.26 legal adoption, unless the adoption is not completed within two years;

275.27 (10) programs licensed by the commissioner of corrections;

275.28 (11) recreation programs for children or adults that are operated or approved by a park
275.29 and recreation board whose primary purpose is to provide social and recreational activities;

275.30 (12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA
275.31 as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in

276.1 section 315.51, whose primary purpose is to provide child care or services to school-age
276.2 children;

276.3 (13) Head Start nonresidential programs which operate for less than 45 days in each
276.4 calendar year;

276.5 (14) noncertified boarding care homes unless they provide services for five or more
276.6 persons whose primary diagnosis is mental illness or a developmental disability;

276.7 (15) programs for children such as scouting, boys clubs, girls clubs, and sports and art
276.8 programs, and nonresidential programs for children provided for a cumulative total of less
276.9 than 30 days in any 12-month period;

276.10 (16) residential programs for persons with mental illness, that are located in hospitals;

276.11 (17) the religious instruction of school-age children; Sabbath or Sunday schools; or the
276.12 congregate care of children by a church, congregation, or religious society during the period
276.13 used by the church, congregation, or religious society for its regular worship;

276.14 (18) camps licensed by the commissioner of health under Minnesota Rules, chapter
276.15 4630;

276.16 (19) mental health outpatient services for adults with mental illness or children with
276.17 emotional disturbance;

276.18 (20) residential programs serving school-age children whose sole purpose is cultural or
276.19 educational exchange, until the commissioner adopts appropriate rules;

276.20 (21) community support services programs as defined in section 245.462, subdivision
276.21 6, and family community support services as defined in section 245.4871, subdivision 17;

276.22 (22) the placement of a child by a birth parent or legal guardian in a preadoptive home
276.23 for purposes of adoption as authorized by section 259.47;

276.24 (23) settings registered under chapter 144D which provide home care services licensed
276.25 by the commissioner of health to fewer than seven adults;

276.26 (24) ~~chemical dependency or substance abuse~~ use disorder treatment activities of licensed
276.27 professionals in private practice as defined in ~~Minnesota Rules, part 9530.6405, subpart 15,~~
276.28 ~~when the treatment activities are not paid for by the consolidated chemical dependency~~
276.29 ~~treatment fund~~ section 245G.01, subdivision 17;

276.30 (25) consumer-directed community support service funded under the Medicaid waiver
276.31 for persons with developmental disabilities when the individual who provided the service
276.32 is:

277.1 (i) the same individual who is the direct payee of these specific waiver funds or paid by
277.2 a fiscal agent, fiscal intermediary, or employer of record; and

277.3 (ii) not otherwise under the control of a residential or nonresidential program that is
277.4 required to be licensed under this chapter when providing the service;

277.5 (26) a program serving only children who are age 33 months or older, that is operated
277.6 by a nonpublic school, for no more than four hours per day per child, with no more than 20
277.7 children at any one time, and that is accredited by:

277.8 (i) an accrediting agency that is formally recognized by the commissioner of education
277.9 as a nonpublic school accrediting organization; or

277.10 (ii) an accrediting agency that requires background studies and that receives and
277.11 investigates complaints about the services provided.

277.12 A program that asserts its exemption from licensure under item (ii) shall, upon request
277.13 from the commissioner, provide the commissioner with documentation from the accrediting
277.14 agency that verifies: that the accreditation is current; that the accrediting agency investigates
277.15 complaints about services; and that the accrediting agency's standards require background
277.16 studies on all people providing direct contact services; ~~or~~

277.17 (27) a program operated by a nonprofit organization incorporated in Minnesota or another
277.18 state that serves youth in kindergarten through grade 12; provides structured, supervised
277.19 youth development activities; and has learning opportunities take place before or after
277.20 school, on weekends, or during the summer or other seasonal breaks in the school calendar.
277.21 A program exempt under this clause is not eligible for child care assistance under chapter
277.22 119B. A program exempt under this clause must:

277.23 (i) have a director or supervisor on site who is responsible for overseeing written policies
277.24 relating to the management and control of the daily activities of the program, ensuring the
277.25 health and safety of program participants, and supervising staff and volunteers;

277.26 (ii) have obtained written consent from a parent or legal guardian for each youth
277.27 participating in activities at the site; and

277.28 (iii) have provided written notice to a parent or legal guardian for each youth at the site
277.29 that the program is not licensed or supervised by the state of Minnesota and is not eligible
277.30 to receive child care assistance payments;

277.31 (28) a county that is an eligible vendor under section 254B.05 to provide care coordination
277.32 and comprehensive assessment services; or

278.1 (29) a recovery community organization that is an eligible vendor under section 254B.05
 278.2 to provide peer recovery support services.

278.3 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
 278.4 building in which a nonresidential program is located if it shares a common wall with the
 278.5 building in which the nonresidential program is located or is attached to that building by
 278.6 skyway, tunnel, atrium, or common roof.

278.7 (c) Except for the home and community-based services identified in section 245D.03,
 278.8 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
 278.9 provided and funded according to an approved federal waiver plan where licensure is
 278.10 specifically identified as not being a condition for the services and funding.

278.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

278.12 Sec. 8. Minnesota Statutes 2016, section 245A.191, is amended to read:

278.13 **245A.191 PROVIDER ELIGIBILITY FOR PAYMENTS FROM THE CHEMICAL**
 278.14 **DEPENDENCY CONSOLIDATED TREATMENT FUND.**

278.15 (a) When a ~~chemical dependency~~ substance use disorder treatment provider licensed
 278.16 under this chapter, and governed by the standards of chapter 245G or Minnesota Rules,
 278.17 parts 2960.0430 to 2960.0490 ~~or 9530.6405 to 9530.6505~~, agrees to meet the applicable
 278.18 requirements under section 254B.05, subdivision 5, ~~paragraphs (b), clauses (1) to (4) and~~
 278.19 ~~(6), (e), and (e)~~, to be eligible for enhanced funding from the chemical dependency
 278.20 consolidated treatment fund, the applicable requirements under section 254B.05 are also
 278.21 licensing requirements that may be monitored for compliance through licensing investigations
 278.22 and licensing inspections.

278.23 (b) Noncompliance with the requirements identified under paragraph (a) may result in:

278.24 (1) a correction order or a conditional license under section 245A.06, or sanctions under
 278.25 section 245A.07;

278.26 (2) nonpayment of claims submitted by the license holder for public program
 278.27 reimbursement;

278.28 (3) recovery of payments made for the service;

278.29 (4) disenrollment in the public payment program; or

278.30 (5) other administrative, civil, or criminal penalties as provided by law.

278.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

279.1 Sec. 9. [245G.01] DEFINITIONS.

279.2 Subdivision 1. Scope. The terms used in this chapter have the meanings given them.

279.3 Subd. 2. Administration of medication. "Administration of medication" means providing
279.4 a medication to a client, and includes the following tasks, performed in the following order:

279.5 (1) checking the client's medication record;

279.6 (2) preparing the medication for administration;

279.7 (3) administering the medication to the client;

279.8 (4) documenting the administration of the medication, or the reason for not administering
279.9 a medication as prescribed; and

279.10 (5) reporting information to a licensed practitioner or a nurse regarding a problem with
279.11 the administration of medication or the client's refusal to take the medication, if applicable.

279.12 Subd. 3. Adolescent. "Adolescent" means an individual under 18 years of age.

279.13 Subd. 4. Alcohol and drug counselor. "Alcohol and drug counselor" has the meaning
279.14 given in section 148F.01, subdivision 5.

279.15 Subd. 5. Applicant. "Applicant" has the meaning given in section 245A.02, subdivision
279.16 3.

279.17 Subd. 6. Capacity management system. "Capacity management system" means a
279.18 database maintained by the department to compile and make information available to the
279.19 public about the waiting list status and current admission capability of each opioid treatment
279.20 program.

279.21 Subd. 7. Central registry. "Central registry" means a database maintained by the
279.22 department to collect identifying information from two or more programs about an individual
279.23 applying for maintenance treatment or detoxification treatment for opioid addiction to
279.24 prevent an individual's concurrent enrollment in more than one program.

279.25 Subd. 8. Client. "Client" means an individual accepted by a license holder for assessment
279.26 or treatment of a substance use disorder. An individual remains a client until the license
279.27 holder no longer provides or intends to provide the individual with treatment service.

279.28 Subd. 9. Commissioner. "Commissioner" means the commissioner of human services.

279.29 Subd. 10. Co-occurring disorders. "Co-occurring disorders" means a diagnosis of both
279.30 a substance use disorder and a mental health disorder.

279.31 Subd. 11. Department. "Department" means the Department of Human Services.

280.1 Subd. 12. **Direct contact.** "Direct contact" has the meaning given for "direct contact"
280.2 in section 245C.02, subdivision 11.

280.3 Subd. 13. **Face-to-face.** "Face-to-face" means two-way, real-time, interactive and visual
280.4 communication between a client and a treatment service provider and includes services
280.5 delivered in person or via telemedicine.

280.6 Subd. 14. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

280.7 Subd. 15. **License holder.** "License holder" has the meaning given in section 245A.02,
280.8 subdivision 9.

280.9 Subd. 16. **Licensed practitioner.** "Licensed practitioner" means an individual who is
280.10 authorized to prescribe medication as defined in section 151.01, subdivision 23.

280.11 Subd. 17. **Licensed professional in private practice.** "Licensed professional in private
280.12 practice" means an individual who:

280.13 (1) is licensed under chapter 148F, or is exempt from licensure under that chapter but
280.14 is otherwise licensed to provide alcohol and drug counseling services;

280.15 (2) practices solely within the permissible scope of the individual's license as defined
280.16 in the law authorizing licensure; and

280.17 (3) does not affiliate with other licensed or unlicensed professionals to provide alcohol
280.18 and drug counseling services. Affiliation does not include conferring with another
280.19 professional or making a client referral.

280.20 Subd. 18. **Nurse.** "Nurse" means an individual licensed and currently registered to
280.21 practice professional or practical nursing as defined in section 148.171, subdivisions 14 and
280.22 15.

280.23 Subd. 19. **Opioid treatment program or OTP.** "Opioid treatment program" or "OTP"
280.24 means a program or practitioner engaged in opioid treatment of an individual that provides
280.25 dispensing of an opioid agonist treatment medication, along with a comprehensive range
280.26 of medical and rehabilitative services, when clinically necessary, to an individual to alleviate
280.27 the adverse medical, psychological, or physical effects of an opioid addiction. OTP includes
280.28 detoxification treatment, short-term detoxification treatment, long-term detoxification
280.29 treatment, maintenance treatment, comprehensive maintenance treatment, and interim
280.30 maintenance treatment.

280.31 Subd. 20. **Paraprofessional.** "Paraprofessional" means an employee, agent, or
280.32 independent contractor of the license holder who performs tasks to support treatment service.

281.1 A paraprofessional may be referred to by a variety of titles including but not limited to
281.2 technician, case aide, or counselor assistant. If currently a client of the license holder, the
281.3 client cannot be a paraprofessional for the license holder.

281.4 Subd. 21. **Student intern.** "Student intern" means an individual who is authorized by a
281.5 licensing board to provide services under supervision of a licensed professional.

281.6 Subd. 22. **Substance.** "Substance" means alcohol, solvents, controlled substances as
281.7 defined in section 152.01, subdivision 4, and other mood-altering substances.

281.8 Subd. 23. **Substance use disorder.** "Substance use disorder" has the meaning given in
281.9 the current Diagnostic and Statistical Manual of Mental Disorders.

281.10 Subd. 24. **Substance use disorder treatment.** "Substance use disorder treatment" means
281.11 treatment of a substance use disorder, including the process of assessment of a client's needs,
281.12 development of planned methods, including interventions or services to address a client's
281.13 needs, provision of services, facilitation of services provided by other service providers,
281.14 and ongoing reassessment by a qualified professional when indicated. The goal of substance
281.15 use disorder treatment is to assist or support the client's efforts to recover from a substance
281.16 use disorder.

281.17 Subd. 25. **Target population.** "Target population" means individuals with a substance
281.18 use disorder and the specified characteristics that a license holder proposes to serve.

281.19 Subd. 26. **Telemedicine.** "Telemedicine" means the delivery of a substance use disorder
281.20 treatment service while the client is at an originating site and the licensed health care provider
281.21 is at a distant site as specified in section 254B.05, subdivision 5, paragraph (f).

281.22 Subd. 27. **Treatment director.** "Treatment director" means an individual who meets
281.23 the qualifications specified in section 245G.11, subdivisions 1 and 3, and is designated by
281.24 the license holder to be responsible for all aspects of the delivery of treatment service.

281.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

281.26 Sec. 10. **[245G.02] APPLICABILITY.**

281.27 Subdivision 1. **Applicability.** Except as provided in subdivisions 2 and 3, no person,
281.28 corporation, partnership, voluntary association, controlling individual, or other organization
281.29 may provide a substance use disorder treatment service to an individual with a substance
281.30 use disorder unless licensed by the commissioner.

281.31 Subd. 2. **Exemption from license requirement.** This chapter does not apply to a county
281.32 or recovery community organization that is providing a service for which the county or

282.1 recovery community organization is an eligible vendor under section 254B.05. This chapter
 282.2 does not apply to an organization whose primary functions are information, referral,
 282.3 diagnosis, case management, and assessment for the purposes of client placement, education,
 282.4 support group services, or self-help programs. This chapter does not apply to the activities
 282.5 of a licensed professional in private practice.

282.6 Subd. 3. **Excluded hospitals.** This chapter does not apply to substance use disorder
 282.7 treatment provided by a hospital licensed under chapter 62J, or under sections 144.50 to
 282.8 144.56, unless the hospital accepts funds for substance use disorder treatment from the
 282.9 consolidated chemical dependency treatment fund under chapter 254B, medical assistance
 282.10 under chapter 256B, or MinnesotaCare or health care cost containment under chapter 256L,
 282.11 or general assistance medical care formerly codified in chapter 256D.

282.12 Subd. 4. **Applicability of Minnesota Rules, chapter 2960.** A residential adolescent
 282.13 substance use disorder treatment program serving an individual younger than 16 years of
 282.14 age must be licensed according to Minnesota Rules, chapter 2960.

282.15 **EFFECTIVE DATE.** This section is effective January 1, 2018.

282.16 Sec. 11. **[245G.03] LICENSING REQUIREMENTS.**

282.17 Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance
 282.18 use disorder treatment must comply with the general requirements in chapters 245A and
 282.19 245C, sections 626.556 and 626.557, and Minnesota Rules, chapter 9544.

282.20 (b) The commissioner may grant variances to the requirements in this chapter that do
 282.21 not affect the client's health or safety if the conditions in section 245A.04, subdivision 9,
 282.22 are met.

282.23 Subd. 2. **Application.** Before the commissioner issues a license, an applicant must
 282.24 submit, on forms provided by the commissioner, any documents the commissioner requires.

282.25 Subd. 3. **Change in license terms.** (a) The commissioner must determine whether a
 282.26 new license is needed when a change in clauses (1) to (4) occurs. A license holder must
 282.27 notify the commissioner before a change in one of the following occurs:

282.28 (1) the Department of Health's licensure of the program;

282.29 (2) whether the license holder provides services specified in sections 245G.18 to 245G.22;

282.30 (3) location; or

282.31 (4) capacity if the license holder meets the requirements of section 245G.21.

283.1 (b) A license holder must notify the commissioner and must apply for a new license if
283.2 there is a change in program ownership.

283.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

283.4 Sec. 12. **[245G.04] INITIAL SERVICES PLAN.**

283.5 (a) The license holder must complete an initial services plan on the day of service
283.6 initiation. The plan must address the client's immediate health and safety concerns, identify
283.7 the needs to be addressed in the first treatment session, and make treatment suggestions for
283.8 the client during the time between intake and completion of the individual treatment plan.

283.9 (b) The initial services plan must include a determination of whether a client is a
283.10 vulnerable adult as defined in section 626.5572, subdivision 21. An adult client of a
283.11 residential program is a vulnerable adult. An individual abuse prevention plan, according
283.12 to sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph
283.13 (b), is required for a client who meets the definition of vulnerable adult.

283.14 **EFFECTIVE DATE.** This section is effective January 1, 2018.

283.15 Sec. 13. **[245G.05] COMPREHENSIVE ASSESSMENT AND ASSESSMENT**
283.16 **SUMMARY.**

283.17 Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the
283.18 client's substance use disorder must be administered face-to-face by an alcohol and drug
283.19 counselor within three calendar days after service initiation for a residential program or
283.20 during the initial session for all other programs. If the comprehensive assessment is not
283.21 completed during the initial session, the client-centered reason for the delay must be
283.22 documented in the client's file and the planned completion date. If the client received a
283.23 comprehensive assessment that authorized the treatment service, an alcohol and drug
283.24 counselor must review the assessment to determine compliance with this subdivision,
283.25 including applicable timelines. If available, the alcohol and drug counselor may use current
283.26 information provided by a referring agency or other source as a supplement. Information
283.27 gathered more than 45 days before the date of admission is not considered current. The
283.28 comprehensive assessment must include sufficient information to complete the assessment
283.29 summary according to subdivision 2 and the individual treatment plan according to section
283.30 245G.06. The comprehensive assessment must include information about the client's needs
283.31 that relate to substance use and personal strengths that support recovery, including:

- 284.1 (1) age, sex, cultural background, sexual orientation, living situation, economic status,
284.2 and level of education;
- 284.3 (2) circumstances of service initiation;
- 284.4 (3) previous attempts at treatment for substance misuse or substance use disorder,
284.5 compulsive gambling, or mental illness;
- 284.6 (4) substance use history including amounts and types of substances used, frequency
284.7 and duration of use, periods of abstinence, and circumstances of relapse, if any. For each
284.8 substance used within the previous 30 days, the information must include the date of the
284.9 most recent use and previous withdrawal symptoms;
- 284.10 (5) specific problem behaviors exhibited by the client when under the influence of
284.11 substances;
- 284.12 (6) family status, family history, including history or presence of physical or sexual
284.13 abuse, level of family support, and substance misuse or substance use disorder of a family
284.14 member or significant other;
- 284.15 (7) physical concerns or diagnoses, the severity of the concerns, and whether the concerns
284.16 are being addressed by a health care professional;
- 284.17 (8) mental health history and psychiatric status, including symptoms, disability, current
284.18 treatment supports, and psychotropic medication needed to maintain stability; the assessment
284.19 must utilize screening tools approved by the commissioner pursuant to section 245.4863 to
284.20 identify whether the client screens positive for co-occurring disorders;
- 284.21 (9) arrests and legal interventions related to substance use;
- 284.22 (10) ability to function appropriately in work and educational settings;
- 284.23 (11) ability to understand written treatment materials, including rules and the client's
284.24 rights;
- 284.25 (12) risk-taking behavior, including behavior that puts the client at risk of exposure to
284.26 blood-borne or sexually transmitted diseases;
- 284.27 (13) social network in relation to expected support for recovery and leisure time activities
284.28 that are associated with substance use;
- 284.29 (14) whether the client is pregnant and, if so, the health of the unborn child and the
284.30 client's current involvement in prenatal care;

285.1 (15) whether the client recognizes problems related to substance use and is willing to
285.2 follow treatment recommendations; and

285.3 (16) collateral information. If the assessor gathered sufficient information from the
285.4 referral source or the client to apply the criteria in parts 9530.6620 and 9530.6622, a collateral
285.5 contact is not required.

285.6 (b) If the client is identified as having opioid use disorder or seeking treatment for opioid
285.7 use disorder, the program must provide educational information to the client concerning:

285.8 (1) risks for opioid use disorder and dependence;

285.9 (2) treatment options, including the use of a medication for opioid use disorder;

285.10 (3) the risk of and recognizing opioid overdose; and

285.11 (4) the use, availability, and administration of naloxone to respond to opioid overdose.

285.12 (c) The commissioner shall develop educational materials that are supported by research
285.13 and updated periodically. The license holder must use the educational materials that are
285.14 approved by the commissioner to comply with this requirement.

285.15 (d) If the comprehensive assessment is completed to authorize treatment service for the
285.16 client, at the earliest opportunity during the assessment interview the assessor shall determine
285.17 if:

285.18 (1) the client is in severe withdrawal and likely to be a danger to self or others;

285.19 (2) the client has severe medical problems that require immediate attention; or

285.20 (3) the client has severe emotional or behavioral symptoms that place the client or others
285.21 at risk of harm.

285.22 If one or more of the conditions in clauses (1) to (3) are present, the assessor must end the
285.23 assessment interview and follow the procedures in the program's medical services plan
285.24 under section 245G.08, subdivision 2, to help the client obtain the appropriate services. The
285.25 assessment interview may resume when the condition is resolved.

285.26 Subd. 2. **Assessment summary.** (a) An alcohol and drug counselor must complete an
285.27 assessment summary within three calendar days after service initiation for a residential
285.28 program and within three sessions for all other programs. If the comprehensive assessment
285.29 is used to authorize the treatment service, the alcohol and drug counselor must prepare an
285.30 assessment summary on the same date the comprehensive assessment is completed. If the
285.31 comprehensive assessment and assessment summary are to authorize treatment services,

286.1 the assessor must determine appropriate services for the client using the dimensions in
286.2 Minnesota Rules, part 9530.6622, and document the recommendations.

286.3 (b) An assessment summary must include:

286.4 (1) a risk description according to section 245G.05 for each dimension listed in paragraph

286.5 (c);

286.6 (2) a narrative summary supporting the risk descriptions; and

286.7 (3) a determination of whether the client has a substance use disorder.

286.8 (c) An assessment summary must contain information relevant to treatment service
286.9 planning and recorded in the dimensions in clauses (1) to (6). The license holder must
286.10 consider:

286.11 (1) Dimension 1, acute intoxication/withdrawal potential; the client's ability to cope with
286.12 withdrawal symptoms and current state of intoxication;

286.13 (2) Dimension 2, biomedical conditions and complications; the degree to which any
286.14 physical disorder of the client would interfere with treatment for substance use, and the
286.15 client's ability to tolerate any related discomfort. The license holder must determine the
286.16 impact of continued chemical use on the unborn child, if the client is pregnant;

286.17 (3) Dimension 3, emotional, behavioral, and cognitive conditions and complications;
286.18 the degree to which any condition or complication is likely to interfere with treatment for
286.19 substance use or with functioning in significant life areas and the likelihood of harm to self
286.20 or others;

286.21 (4) Dimension 4, readiness for change; the support necessary to keep the client involved
286.22 in treatment service;

286.23 (5) Dimension 5, relapse, continued use, and continued problem potential; the degree
286.24 to which the client recognizes relapse issues and has the skills to prevent relapse of either
286.25 substance use or mental health problems; and

286.26 (6) Dimension 6, recovery environment; whether the areas of the client's life are
286.27 supportive of or antagonistic to treatment participation and recovery.

286.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

286.29 Sec. 14. **[245G.06] INDIVIDUAL TREATMENT PLAN.**

286.30 Subdivision 1. **General.** Each client must have an individual treatment plan developed
286.31 by an alcohol and drug counselor within seven days of service initiation for a residential

287.1 program and within three sessions for all other programs. The client must have active, direct
287.2 involvement in selecting the anticipated outcomes of the treatment process and developing
287.3 the treatment plan. The individual treatment plan must be signed by the client and the alcohol
287.4 and drug counselor and document the client's involvement in the development of the plan.
287.5 The plan may be a continuation of the initial services plan required in section 245G.04.
287.6 Treatment planning must include ongoing assessment of client needs. An individual treatment
287.7 plan must be updated based on new information gathered about the client's condition and
287.8 on whether methods identified have the intended effect. A change to the plan must be signed
287.9 by the client and the alcohol and drug counselor. The plan must provide for the involvement
287.10 of the client's family and people selected by the client as important to the success of treatment
287.11 at the earliest opportunity, consistent with the client's treatment needs and written consent.

287.12 Subd. 2. **Plan contents.** An individual treatment plan must be recorded in the six
287.13 dimensions listed in section 245G.05, subdivision 2, paragraph (c), must address each issue
287.14 identified in the assessment summary, prioritized according to the client's needs and focus,
287.15 and must include:

287.16 (1) specific methods to address each identified need, including amount, frequency, and
287.17 anticipated duration of treatment service. The methods must be appropriate to the client's
287.18 language, reading skills, cultural background, and strengths;

287.19 (2) resources to refer the client to when the client's needs are to be addressed concurrently
287.20 by another provider; and

287.21 (3) goals the client must reach to complete treatment and terminate services.

287.22 Subd. 3. **Documentation of treatment services; treatment plan review.** (a) A review
287.23 of all treatment services must be documented weekly and include a review of:

287.24 (1) care coordination activities;

287.25 (2) medical and other appointments the client attended;

287.26 (3) issues related to medications that are not documented in the medication administration
287.27 record; and

287.28 (4) issues related to attendance for treatment services, including the reason for any client
287.29 absence from a treatment service.

287.30 (b) A note must be entered immediately following any significant event. A significant
287.31 event is an event that impacts the client's relationship with other clients, staff, the client's
287.32 family, or the client's treatment plan.

288.1 (c) A treatment plan review must be entered in a client's file weekly or after each treatment
288.2 service, whichever is less frequent, by the staff member providing the service. The review
288.3 must indicate the span of time covered by the review and each of the six dimensions listed
288.4 in section 245G.05, subdivision 2, paragraph (c). The review must:

288.5 (1) indicate the date, type, and amount of each treatment service provided and the client's
288.6 response to each service;

288.7 (2) address each goal in the treatment plan and whether the methods to address the goals
288.8 are effective;

288.9 (3) include monitoring of any physical and mental health problems;

288.10 (4) document the participation of others;

288.11 (5) document staff recommendations for changes in the methods identified in the treatment
288.12 plan and whether the client agrees with the change; and

288.13 (6) include a review and evaluation of the individual abuse prevention plan according
288.14 to section 245A.65.

288.15 (d) Each entry in a client's record must be accurate, legible, signed, and dated. A late
288.16 entry must be clearly labeled "late entry." A correction to an entry must be made in a way
288.17 in which the original entry can still be read.

288.18 Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a
288.19 discharge summary for each client. The summary must be completed within five days of
288.20 the client's service termination or within five days from the client's or program's decision
288.21 to terminate services, whichever is earlier.

288.22 (b) The service discharge summary must be recorded in the six dimensions listed in
288.23 section 245G.05, subdivision 2, paragraph (c), and include the following information:

288.24 (1) the client's issues, strengths, and needs while participating in treatment, including
288.25 services provided;

288.26 (2) the client's progress toward achieving each goal identified in the individual treatment
288.27 plan;

288.28 (3) a risk description according to section 245G.05; and

288.29 (4) the reasons for and circumstances of service termination. If a program discharges a
288.30 client at staff request, the reason for discharge and the procedure followed for the decision
288.31 to discharge must be documented and comply with the program's policies on staff-initiated
288.32 client discharge. If a client is discharged at staff request, the program must give the client

289.1 crisis and other referrals appropriate for the client's needs and offer assistance to the client
289.2 to access the services.

289.3 (c) For a client who successfully completes treatment, the summary must also include:

289.4 (1) the client's living arrangements at service termination;

289.5 (2) continuing care recommendations, including transitions between more or less intense
289.6 services, or more frequent to less frequent services, and referrals made with specific attention
289.7 to continuity of care for mental health, as needed;

289.8 (3) service termination diagnosis; and

289.9 (4) the client's prognosis.

289.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

289.11 Sec. 15. **[245G.07] TREATMENT SERVICE.**

289.12 Subdivision 1. **Treatment service.** (a) A license holder must offer the following treatment
289.13 services, unless clinically inappropriate and the justifying clinical rationale is documented:

289.14 (1) individual and group counseling to help the client identify and address needs related
289.15 to substance use and develop strategies to avoid harmful substance use after discharge and
289.16 to help the client obtain the services necessary to establish a lifestyle free of the harmful
289.17 effects of substance use disorder;

289.18 (2) client education strategies to avoid inappropriate substance use and health problems
289.19 related to substance use and the necessary lifestyle changes to regain and maintain health.

289.20 Client education must include information on tuberculosis education on a form approved
289.21 by the commissioner, the human immunodeficiency virus according to section 245A.19,
289.22 other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis.

289.23 A licensed alcohol and drug counselor must be present during an educational group;

289.24 (3) a service to help the client integrate gains made during treatment into daily living
289.25 and to reduce the client's reliance on a staff member for support;

289.26 (4) a service to address issues related to co-occurring disorders, including client education
289.27 on symptoms of mental illness, the possibility of comorbidity, and the need for continued
289.28 medication compliance while recovering from substance use disorder. A group must address
289.29 co-occurring disorders, as needed. When treatment for mental health problems is indicated,
289.30 the treatment must be integrated into the client's individual treatment plan;

290.1 (5) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
290.2 services provided one-to-one by an individual in recovery. Peer support services include
290.3 education, advocacy, mentoring through self-disclosure of personal recovery experiences,
290.4 attending recovery and other support groups with a client, accompanying the client to
290.5 appointments that support recovery, assistance accessing resources to obtain housing,
290.6 employment, education, and advocacy services, and nonclinical recovery support to assist
290.7 the transition from treatment into the recovery community; and

290.8 (6) on July 1, 2018, or upon federal approval, whichever is later, care coordination
290.9 provided by an individual who meets the staff qualifications in section 245G.11, subdivision
290.10 7. Care coordination services include:

290.11 (i) assistance in coordination with significant others to help in the treatment planning
290.12 process whenever possible;

290.13 (ii) assistance in coordination with and follow up for medical services as identified in
290.14 the treatment plan;

290.15 (iii) facilitation of referrals to substance use disorder services as indicated by a client's
290.16 medical provider, comprehensive assessment, or treatment plan;

290.17 (iv) facilitation of referrals to mental health services as identified by a client's
290.18 comprehensive assessment or treatment plan;

290.19 (v) assistance with referrals to economic assistance, social services, housing resources,
290.20 and prenatal care according to the client's needs;

290.21 (vi) life skills advocacy and support accessing treatment follow-up, disease management,
290.22 and education services, including referral and linkages to long-term services and supports
290.23 as needed; and

290.24 (vii) documentation of the provision of care coordination services in the client's file.

290.25 (b) A treatment service provided to a client must be provided according to the individual
290.26 treatment plan and must consider cultural differences and special needs of a client.

290.27 Subd. 2. **Additional treatment service.** A license holder may provide or arrange the
290.28 following additional treatment service as a part of the client's individual treatment plan:

290.29 (1) relationship counseling provided by a qualified professional to help the client identify
290.30 the impact of the client's substance use disorder on others and to help the client and persons
290.31 in the client's support structure identify and change behaviors that contribute to the client's
290.32 substance use disorder;

291.1 (2) therapeutic recreation to allow the client to participate in recreational activities
 291.2 without the use of mood-altering chemicals and to plan and select leisure activities that do
 291.3 not involve the inappropriate use of chemicals;

291.4 (3) stress management and physical well-being to help the client reach and maintain an
 291.5 appropriate level of health, physical fitness, and well-being;

291.6 (4) living skills development to help the client learn basic skills necessary for independent
 291.7 living;

291.8 (5) employment or educational services to help the client become financially independent;

291.9 (6) socialization skills development to help the client live and interact with others in a
 291.10 positive and productive manner; and

291.11 (7) room, board, and supervision at the treatment site to provide the client with a safe
 291.12 and appropriate environment to gain and practice new skills.

291.13 Subd. 3. **Counselors.** A treatment service, including therapeutic recreation, must be
 291.14 provided by an alcohol and drug counselor according to section 245G.11, unless the
 291.15 individual providing the service is specifically qualified according to the accepted credential
 291.16 required to provide the service. Therapeutic recreation does not include planned leisure
 291.17 activities.

291.18 Subd. 4. **Location of service provision.** The license holder may provide services at any
 291.19 of the license holder's licensed locations or at another suitable location including a school,
 291.20 government building, medical or behavioral health facility, or social service organization,
 291.21 upon notification and approval of the commissioner. If services are provided off site from
 291.22 the licensed site, the reason for the provision of services remotely must be documented.

291.23 **EFFECTIVE DATE.** This section is effective January 1, 2018.

291.24 Sec. 16. **[245G.08] MEDICAL SERVICES.**

291.25 Subdivision 1. **Health care services.** An applicant or license holder must maintain a
 291.26 complete description of the health care services, nursing services, dietary services, and
 291.27 emergency physician services offered by the applicant or license holder.

291.28 Subd. 2. **Procedures.** The applicant or license holder must have written procedures for
 291.29 obtaining a medical intervention for a client, that are approved in writing by a physician
 291.30 who is licensed under chapter 147, unless:

291.31 (1) the license holder does not provide a service under section 245G.21; and

292.1 (2) a medical intervention is referred to 911, the emergency telephone number, or the
292.2 client's physician.

292.3 Subd. 3. **Standing order protocol.** A license holder that maintains a supply of naloxone
292.4 available for emergency treatment of opioid overdose must have a written standing order
292.5 protocol by a physician who is licensed under chapter 147, that permits the license holder
292.6 to maintain a supply of naloxone on site, and must require staff to undergo specific training
292.7 in administration of naloxone.

292.8 Subd. 4. **Consultation services.** The license holder must have access to and document
292.9 the availability of a licensed mental health professional to provide diagnostic assessment
292.10 and treatment planning assistance.

292.11 Subd. 5. **Administration of medication and assistance with self-medication.** (a) A
292.12 license holder must meet the requirements in this subdivision if a service provided includes
292.13 the administration of medication.

292.14 (b) A staff member, other than a licensed practitioner or nurse, who is delegated by a
292.15 licensed practitioner or a registered nurse the task of administration of medication or assisting
292.16 with self-medication, must:

292.17 (1) successfully complete a medication administration training program for unlicensed
292.18 personnel through an accredited Minnesota postsecondary educational institution. A staff
292.19 member's completion of the course must be documented in writing and placed in the staff
292.20 member's personnel file;

292.21 (2) be trained according to a formalized training program that is taught by a registered
292.22 nurse and offered by the license holder. The training must include the process for
292.23 administration of naloxone, if naloxone is kept on site. A staff member's completion of the
292.24 training must be documented in writing and placed in the staff member's personnel records;
292.25 or

292.26 (3) demonstrate to a registered nurse competency to perform the delegated activity. A
292.27 registered nurse must be employed or contracted to develop the policies and procedures for
292.28 administration of medication or assisting with self-administration of medication, or both.

292.29 (c) A registered nurse must provide supervision as defined in section 148.171, subdivision
292.30 23. The registered nurse's supervision must include, at a minimum, monthly on-site
292.31 supervision or more often if warranted by a client's health needs. The policies and procedures
292.32 must include:

293.1 (1) a provision that a delegation of administration of medication is limited to the
293.2 administration of a medication that is administered orally, topically, or as a suppository, an
293.3 eye drop, an ear drop, or an inhalant;

293.4 (2) a provision that each client's file must include documentation indicating whether
293.5 staff must conduct the administration of medication or the client must self-administer
293.6 medication, or both;

293.7 (3) a provision that a client may carry emergency medication such as nitroglycerin as
293.8 instructed by the client's physician;

293.9 (4) a provision for the client to self-administer medication when a client is scheduled to
293.10 be away from the facility;

293.11 (5) a provision that if a client self-administers medication when the client is present in
293.12 the facility, the client must self-administer medication under the observation of a trained
293.13 staff member;

293.14 (6) a provision that when a license holder serves a client who is a parent with a child,
293.15 the parent may only administer medication to the child under a staff member's supervision;

293.16 (7) requirements for recording the client's use of medication, including staff signatures
293.17 with date and time;

293.18 (8) guidelines for when to inform a nurse of problems with self-administration of
293.19 medication, including a client's failure to administer, refusal of a medication, adverse
293.20 reaction, or error; and

293.21 (9) procedures for acceptance, documentation, and implementation of a prescription,
293.22 whether written, verbal, telephonic, or electronic.

293.23 Subd. 6. **Control of drugs.** A license holder must have and implement written policies
293.24 and procedures developed by a registered nurse that contain:

293.25 (1) a requirement that each drug must be stored in a locked compartment. A Schedule
293.26 II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked
293.27 compartment, permanently affixed to the physical plant or medication cart;

293.28 (2) a system which accounts for all scheduled drugs each shift;

293.29 (3) a procedure for recording the client's use of medication, including the signature of
293.30 the staff member who completed the administration of the medication with the time and
293.31 date;

293.32 (4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

294.1 (5) a statement that only authorized personnel are permitted access to the keys to a locked
294.2 compartment;

294.3 (6) a statement that no legend drug supply for one client shall be given to another client;
294.4 and

294.5 (7) a procedure for monitoring the available supply of naloxone on site, replenishing
294.6 the naloxone supply when needed, and destroying naloxone according to clause (4).

294.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

294.8 Sec. 17. **[245G.09] CLIENT RECORDS.**

294.9 Subdivision 1. **Client records required.** (a) A license holder must maintain a file of
294.10 current and accurate client records on the premises where the treatment service is provided
294.11 or coordinated. For services provided off site, client records must be available at the program
294.12 and adhere to the same clinical and administrative policies and procedures as services
294.13 provided on site. The content and format of client records must be uniform and entries in
294.14 each record must be signed and dated by the staff member making the entry. Client records
294.15 must be protected against loss, tampering, or unauthorized disclosure according to section
294.16 254A.09, chapter 13, and Code of Federal Regulations, title 42, chapter 1, part 2, subpart
294.17 B, sections 2.1 to 2.67, and title 45, parts 160 to 164.

294.18 (b) The program must have a policy and procedure that identifies how the program will
294.19 track and record client attendance at treatment activities, including the date, duration, and
294.20 nature of each treatment service provided to the client.

294.21 Subd. 2. **Record retention.** The client records of a discharged client must be retained
294.22 by a license holder for seven years. A license holder that ceases to provide treatment service
294.23 must retain client records for seven years from the date of facility closure and must notify
294.24 the commissioner of the location of the client records and the name of the individual
294.25 responsible for maintaining the client's records.

294.26 Subd. 3. **Contents.** Client records must contain the following:

294.27 (1) documentation that the client was given information on client rights and
294.28 responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided
294.29 an orientation to the program abuse prevention plan required under section 245A.65,
294.30 subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record
294.31 must contain documentation that the client was provided educational information according
294.32 to section 245G.05, subdivision 1, paragraph (b);

- 295.1 (2) an initial services plan completed according to section 245G.04;
295.2 (3) a comprehensive assessment completed according to section 245G.05;
295.3 (4) an assessment summary completed according to section 245G.05, subdivision 2;
295.4 (5) an individual abuse prevention plan according to sections 245A.65, subdivision 2,
295.5 and 626.557, subdivision 14, when applicable;
295.6 (6) an individual treatment plan according to section 245G.06, subdivisions 1 and 2;
295.7 (7) documentation of treatment services and treatment plan review according to section
295.8 245G.06, subdivision 3; and
295.9 (8) a summary at the time of service termination according to section 245G.06,
295.10 subdivision 4.

295.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

295.12 Sec. 18. **[245G.10] STAFF REQUIREMENTS.**

295.13 Subdivision 1. **Treatment director.** A license holder must have a treatment director.

295.14 Subd. 2. **Alcohol and drug counselor supervisor.** A license holder must employ an
295.15 alcohol and drug counselor supervisor who meets the requirements of section 245G.11,
295.16 subdivision 4. An individual may be simultaneously employed as a treatment director,
295.17 alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual
295.18 meets the qualifications for each position. If an alcohol and drug counselor is simultaneously
295.19 employed as an alcohol and drug counselor supervisor or treatment director, that individual
295.20 must be considered a 0.5 full-time equivalent alcohol and drug counselor for staff
295.21 requirements under subdivision 4.

295.22 Subd. 3. **Responsible staff member.** A treatment director must designate a staff member
295.23 who, when present in the facility, is responsible for the delivery of treatment service. A
295.24 license holder must have a designated staff member during all hours of operation. A license
295.25 holder providing room and board and treatment at the same site must have a responsible
295.26 staff member on duty 24 hours a day. The designated staff member must know and understand
295.27 the implications of this chapter and sections 245A.65, 626.556, 626.557, and 626.5572.

295.28 Subd. 4. **Staff requirement.** It is the responsibility of the license holder to determine
295.29 an acceptable group size based on each client's needs except that treatment services provided
295.30 in a group shall not exceed 16 clients. A counselor in an opioid treatment program must not
295.31 supervise more than 50 clients. The license holder must maintain a record that documents
295.32 compliance with this subdivision.

296.1 Subd. 5. **Medical emergency.** When a client is present, a license holder must have at
296.2 least one staff member on the premises who has a current American Red Cross standard
296.3 first aid certificate or an equivalent certificate and at least one staff member on the premises
296.4 who has a current American Red Cross community, American Heart Association, or
296.5 equivalent CPR certificate. A single staff member with both certifications satisfies this
296.6 requirement.

296.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

296.8 Sec. 19. **[245G.11] STAFF QUALIFICATIONS.**

296.9 Subdivision 1. **General qualifications.** (a) All staff members who have direct contact
296.10 must be 18 years of age or older. At the time of employment, each staff member must meet
296.11 the qualifications in this subdivision. For purposes of this subdivision, "problematic substance
296.12 use" means a behavior or incident listed by the license holder in the personnel policies and
296.13 procedures according to section 245G.13, subdivision 1, clause (5).

296.14 (b) A treatment director, supervisor, nurse, counselor, student intern, or other professional
296.15 must be free of problematic substance use for at least the two years immediately preceding
296.16 employment and must sign a statement attesting to that fact.

296.17 (c) A paraprofessional, recovery peer, or any other staff member with direct contact
296.18 must be free of problematic substance use for at least one year immediately preceding
296.19 employment and must sign a statement attesting to that fact.

296.20 Subd. 2. **Employment; prohibition on problematic substance use.** A staff member
296.21 with direct contact must be free from problematic substance use as a condition of
296.22 employment, but is not required to sign additional statements. A staff member with direct
296.23 contact who is not free from problematic substance use must be removed from any
296.24 responsibilities that include direct contact for the time period specified in subdivision 1.
296.25 The time period begins to run on the date of the last incident of problematic substance use
296.26 as described in the facility's policies and procedures according to section 245G.13,
296.27 subdivision 1, clause (5).

296.28 Subd. 3. **Treatment directors.** A treatment director must:

296.29 (1) have at least one year of work experience in direct service to an individual with
296.30 substance use disorder or one year of work experience in the management or administration
296.31 of direct service to an individual with substance use disorder;

296.32 (2) have a baccalaureate degree or three years of work experience in administration or
296.33 personnel supervision in human services; and

297.1 (3) know and understand the implications of this chapter, chapter 245A, and sections
297.2 626.556, 626.557, and 626.5572. Demonstration of the treatment director's knowledge must
297.3 be documented in the personnel record.

297.4 Subd. 4. Alcohol and drug counselor supervisors. An alcohol and drug counselor
297.5 supervisor must:

297.6 (1) meet the qualification requirements in subdivision 5;

297.7 (2) have three or more years of experience providing individual and group counseling
297.8 to individuals with substance use disorder; and

297.9 (3) know and understand the implications of this chapter and sections 245A.65, 626.556,
297.10 626.557, and 626.5572.

297.11 Subd. 5. Alcohol and drug counselor qualifications. (a) An alcohol and drug counselor
297.12 must either be licensed or exempt from licensure under chapter 148F.

297.13 (b) An individual who is exempt from licensure under chapter 148F, must meet one of
297.14 the following additional requirements:

297.15 (1) completion of at least a baccalaureate degree with a major or concentration in social
297.16 work, nursing, sociology, human services, or psychology, or licensure as a registered nurse;
297.17 successful completion of a minimum of 120 hours of classroom instruction in which each
297.18 of the core functions listed in chapter 148F is covered; and successful completion of 440
297.19 hours of supervised experience as an alcohol and drug counselor, either as a student or a
297.20 staff member;

297.21 (2) completion of at least 270 hours of drug counselor training in which each of the core
297.22 functions listed in chapter 148F is covered, and successful completion of 880 hours of
297.23 supervised experience as an alcohol and drug counselor, either as a student or as a staff
297.24 member;

297.25 (3) current certification as an alcohol and drug counselor or alcohol and drug counselor
297.26 reciprocal, through the evaluation process established by the International Certification and
297.27 Reciprocity Consortium Alcohol and Other Drug Abuse, Inc.;

297.28 (4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling
297.29 education from an accredited school or educational program and 880 hours of alcohol and
297.30 drug counseling practicum; or

298.1 (5) employment in a program formerly licensed under Minnesota Rules, parts 9530.5000
298.2 to 9530.6400, and successful completion of 6,000 hours of supervised work experience in
298.3 a licensed program as an alcohol and drug counselor prior to January 1, 2005.

298.4 (c) An alcohol and drug counselor may not provide a treatment service that requires
298.5 professional licensure unless the individual possesses the necessary license. For the purposes
298.6 of enforcing this section, the commissioner has the authority to monitor a service provider's
298.7 compliance with the relevant standards of the service provider's profession and may issue
298.8 licensing actions against the license holder according to sections 245A.05, 245A.06, and
298.9 245A.07, based on the commissioner's determination of noncompliance.

298.10 Subd. 6. **Paraprofessionals.** A paraprofessional must have knowledge of client rights,
298.11 according to section 148F.165, and staff member responsibilities. A paraprofessional may
298.12 not admit, transfer, or discharge a client but may be responsible for the delivery of treatment
298.13 service according to section 245G.10, subdivision 3.

298.14 Subd. 7. **Care coordination provider qualifications.** (a) Care coordination must be
298.15 provided by qualified staff. An individual is qualified to provide care coordination if the
298.16 individual:

298.17 (1) is skilled in the process of identifying and assessing a wide range of client needs;

298.18 (2) is knowledgeable about local community resources and how to use those resources
298.19 for the benefit of the client;

298.20 (3) has successfully completed 30 hours of classroom instruction on care coordination
298.21 for an individual with substance use disorder;

298.22 (4) has either:

298.23 (i) a bachelor's degree in one of the behavioral sciences or related fields; or

298.24 (ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest
298.25 Indian Council on Addictive Disorders; and

298.26 (5) has at least 2,000 hours of supervised experience working with individuals with
298.27 substance use disorder.

298.28 (b) A care coordinator must receive at least one hour of supervision regarding individual
298.29 service delivery from an alcohol and drug counselor weekly.

298.30 Subd. 8. **Recovery peer qualifications.** A recovery peer must:

298.31 (1) have a high school diploma or its equivalent;

299.1 (2) have a minimum of one year in recovery from substance use disorder;

299.2 (3) hold a current credential from a certification body approved by the commissioner
299.3 that demonstrates skills and training in the domains of ethics and boundaries, advocacy,
299.4 mentoring and education, and recovery and wellness support; and

299.5 (4) receive ongoing supervision in areas specific to the domains of the recovery peer's
299.6 role by an alcohol and drug counselor or an individual with a certification approved by the
299.7 commissioner.

299.8 Subd. 9. **Volunteers.** A volunteer may provide treatment service when the volunteer is
299.9 supervised and can be seen or heard by a staff member meeting the criteria in subdivision
299.10 4 or 5, but may not practice alcohol and drug counseling unless qualified under subdivision
299.11 5.

299.12 Subd. 10. **Student interns.** A qualified staff member must supervise and be responsible
299.13 for a treatment service performed by a student intern and must review and sign each
299.14 assessment, progress note, and individual treatment plan prepared by a student intern. A
299.15 student intern must receive the orientation and training required in section 245G.13,
299.16 subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be
299.17 students or licensing candidates with time documented to be directly related to the provision
299.18 of treatment services for which the staff are authorized.

299.19 Subd. 11. **Individuals with temporary permit.** An individual with a temporary permit
299.20 from the Board of Behavioral Health and Therapy may provide chemical dependency
299.21 treatment service according to this subdivision if they meet the requirements of either
299.22 paragraph (a) or (b).

299.23 (a) An individual with a temporary permit must be supervised by a licensed alcohol and
299.24 drug counselor assigned by the license holder. The supervising licensed alcohol and drug
299.25 counselor must document the amount and type of supervision provided at least on a weekly
299.26 basis. The supervision must relate to the clinical practice.

299.27 (b) An individual with a temporary permit must be supervised by a clinical supervisor
299.28 approved by the Board of Behavioral Health and Therapy. The supervision must be
299.29 documented and meet the requirements of section 148F.04, subdivision 4.

299.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

300.1 Sec. 20. **[245G.12] PROVIDER POLICIES AND PROCEDURES.**

300.2 A license holder must develop a written policies and procedures manual, indexed
300.3 according to section 245A.04, subdivision 14, paragraph (c), that provides staff members
300.4 immediate access to all policies and procedures and provides a client and other authorized
300.5 parties access to all policies and procedures. The manual must contain the following
300.6 materials:

300.7 (1) assessment and treatment planning policies, including screening for mental health
300.8 concerns and treatment objectives related to the client's identified mental health concerns
300.9 in the client's treatment plan;

300.10 (2) policies and procedures regarding HIV according to section 245A.19;

300.11 (3) the license holder's methods and resources to provide information on tuberculosis
300.12 and tuberculosis screening to each client and to report a known tuberculosis infection
300.13 according to section 144.4804;

300.14 (4) personnel policies according to section 245G.13;

300.15 (5) policies and procedures that protect a client's rights according to section 245G.15;

300.16 (6) a medical services plan according to section 245G.08;

300.17 (7) emergency procedures according to section 245G.16;

300.18 (8) policies and procedures for maintaining client records according to section 245G.09;

300.19 (9) procedures for reporting the maltreatment of minors according to section 626.556,
300.20 and vulnerable adults according to sections 245A.65, 626.557, and 626.5572;

300.21 (10) a description of treatment services, including the amount and type of services
300.22 provided;

300.23 (11) the methods used to achieve desired client outcomes;

300.24 (12) the hours of operation; and

300.25 (13) the target population served.

300.26 **EFFECTIVE DATE.** This section is effective January 1, 2018.

300.27 Sec. 21. **[245G.13] PROVIDER PERSONNEL POLICIES.**

300.28 Subdivision 1. **Personnel policy requirements.** A license holder must have written
300.29 personnel policies that are available to each staff member. The personnel policies must:

301.1 (1) ensure that staff member retention, promotion, job assignment, or pay are not affected
301.2 by a good faith communication between a staff member and the department, the Department
301.3 of Health, the ombudsman for mental health and developmental disabilities, law enforcement,
301.4 or a local agency for the investigation of a complaint regarding a client's rights, health, or
301.5 safety;

301.6 (2) contain a job description for each staff member position specifying responsibilities,
301.7 degree of authority to execute job responsibilities, and qualification requirements;

301.8 (3) provide for a job performance evaluation based on standards of job performance
301.9 conducted on a regular and continuing basis, including a written annual review;

301.10 (4) describe behavior that constitutes grounds for disciplinary action, suspension, or
301.11 dismissal, including policies that address staff member problematic substance use and the
301.12 requirements of section 245G.11, subdivision 1, policies prohibiting personal involvement
301.13 with a client in violation of chapter 604, and policies prohibiting client abuse described in
301.14 sections 245A.65, 626.556, 626.557, and 626.5572;

301.15 (5) identify how the program will identify whether behaviors or incidents are problematic
301.16 substance use, including a description of how the facility must address:

301.17 (i) receiving treatment for substance use within the period specified for the position in
301.18 the staff qualification requirements, including medication-assisted treatment;

301.19 (ii) substance use that negatively impacts the staff member's job performance;

301.20 (iii) chemical use that affects the credibility of treatment services with a client, referral
301.21 source, or other member of the community;

301.22 (iv) symptoms of intoxication or withdrawal on the job; and

301.23 (v) the circumstances under which an individual who participates in monitoring by the
301.24 health professional services program for a substance use or mental health disorder is able
301.25 to provide services to the program's clients;

301.26 (6) include a chart or description of the organizational structure indicating lines of
301.27 authority and responsibilities;

301.28 (7) include orientation within 24 working hours of starting for each new staff member
301.29 based on a written plan that, at a minimum, must provide training related to the staff member's
301.30 specific job responsibilities, policies and procedures, client confidentiality, HIV minimum
301.31 standards, and client needs; and

302.1 (8) include policies outlining the license holder's response to a staff member with a
302.2 behavior problem that interferes with the provision of treatment service.

302.3 Subd. 2. **Staff development.** (a) A license holder must ensure that each staff member
302.4 has the training described in this subdivision.

302.5 (b) Each staff member must be trained every two years in:

302.6 (1) client confidentiality rules and regulations and client ethical boundaries; and

302.7 (2) emergency procedures and client rights as specified in sections 144.651, 148F.165,
302.8 and 253B.03.

302.9 (c) Annually each staff member with direct contact must be trained on mandatory
302.10 reporting as specified in sections 245A.65, 626.556, 626.5561, 626.557, and 626.5572,
302.11 including specific training covering the license holder's policies for obtaining a release of
302.12 client information.

302.13 (d) Upon employment and annually thereafter, each staff member with direct contact
302.14 must receive training on HIV minimum standards according to section 245A.19.

302.15 (e) A treatment director, supervisor, nurse, or counselor must have a minimum of 12
302.16 hours of training in co-occurring disorders that includes competencies related to philosophy,
302.17 trauma-informed care, screening, assessment, diagnosis and person-centered treatment
302.18 planning, documentation, programming, medication, collaboration, mental health
302.19 consultation, and discharge planning. A new staff member who has not obtained the training
302.20 must complete the training within six months of employment. A staff member may request,
302.21 and the license holder may grant, credit for relevant training obtained before employment,
302.22 which must be documented in the staff member's personnel file.

302.23 Subd. 3. **Personnel files.** The license holder must maintain a separate personnel file for
302.24 each staff member. At a minimum, the personnel file must conform to the requirements of
302.25 this chapter. A personnel file must contain the following:

302.26 (1) a completed application for employment signed by the staff member and containing
302.27 the staff member's qualifications for employment;

302.28 (2) documentation related to the staff member's background study data, according to
302.29 chapter 245C;

302.30 (3) for a staff member who provides psychotherapy services, employer names and
302.31 addresses for the past five years for which the staff member provided psychotherapy services,

303.1 and documentation of an inquiry required by sections 604.20 to 604.205 made to the staff
303.2 member's former employer regarding substantiated sexual contact with a client;

303.3 (4) documentation that the staff member completed orientation and training;

303.4 (5) documentation that the staff member meets the requirements in section 245G.11;

303.5 (6) documentation demonstrating the staff member's compliance with section 245G.08,
303.6 subdivision 3, for a staff member who conducts administration of medication; and

303.7 (7) documentation demonstrating the staff member's compliance with section 245G.18,
303.8 subdivision 2, for a staff member that treats an adolescent client.

303.9 **EFFECTIVE DATE.** This section is effective January 1, 2018.

303.10 Sec. 22. **[245G.14] SERVICE INITIATION AND TERMINATION POLICIES.**

303.11 Subdivision 1. **Service initiation policy.** A license holder must have a written service
303.12 initiation policy containing service initiation preferences that comply with this section and
303.13 Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria.
303.14 The license holder must not initiate services for an individual who does not meet the service
303.15 initiation criteria. The service initiation criteria must be either posted in the area of the
303.16 facility where services for a client are initiated, or given to each interested person upon
303.17 request. Titles of each staff member authorized to initiate services for a client must be listed
303.18 in the services initiation and termination policies.

303.19 Subd. 2. **License holder responsibilities.** (a) The license holder must have and comply
303.20 with a written protocol for (1) assisting a client in need of care not provided by the license
303.21 holder, and (2) a client who poses a substantial likelihood of harm to the client or others, if
303.22 the behavior is beyond the behavior management capabilities of the staff members.

303.23 (b) A service termination and denial of service initiation that poses an immediate threat
303.24 to the health of any individual or requires immediate medical intervention must be referred
303.25 to a medical facility capable of admitting the client.

303.26 (c) A service termination policy and a denial of service initiation that involves the
303.27 commission of a crime against a license holder's staff member or on a license holder's
303.28 premises, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and
303.29 title 45, parts 160 to 164, must be reported to a law enforcement agency with jurisdiction.

303.30 Subd. 3. **Service termination policies.** A license holder must have a written policy
303.31 specifying the conditions when a client must be terminated from service. The service
303.32 termination policy must include:

304.1 (1) procedures for a client whose services were terminated under subdivision 2;

304.2 (2) a description of client behavior that constitutes reason for a staff-requested service
 304.3 termination and a process for providing this information to a client;

304.4 (3) a requirement that before discharging a client from a residential setting, for not
 304.5 reaching treatment plan goals, the license holder must confer with other interested persons
 304.6 to review the issues involved in the decision. The documentation requirements for a
 304.7 staff-requested service termination must describe why the decision to discharge is warranted,
 304.8 the reasons for the discharge, and the alternatives considered or attempted before discharging
 304.9 the client;

304.10 (4) procedures consistent with section 253B.16, subdivision 2, that staff members must
 304.11 follow when a client admitted under chapter 253B is to have services terminated;

304.12 (5) procedures a staff member must follow when a client leaves against staff or medical
 304.13 advice and when the client may be dangerous to the client or others, including a policy that
 304.14 requires a staff member to assist the client with assessing needs of care or other resources;

304.15 (6) procedures for communicating staff-approved service termination criteria to a client,
 304.16 including the expectations in the client's individual treatment plan according to section
 304.17 245G.06; and

304.18 (7) titles of each staff member authorized to terminate a client's service must be listed
 304.19 in the service initiation and service termination policies.

304.20 **EFFECTIVE DATE.** This section is effective January 1, 2018.

304.21 Sec. 23. **[245G.15] CLIENT RIGHTS PROTECTION.**

304.22 Subdivision 1. **Explanation.** A client has the rights identified in sections 144.651,
 304.23 148F.165, 253B.03, and 254B.02, subdivision 2, as applicable. The license holder must
 304.24 give each client at service initiation a written statement of the client's rights and
 304.25 responsibilities. A staff member must review the statement with a client at that time.

304.26 Subd. 2. **Grievance procedure.** At service initiation, the license holder must explain
 304.27 the grievance procedure to the client or the client's representative. The grievance procedure
 304.28 must be posted in a place visible to clients, and made available upon a client's or former
 304.29 client's request. The grievance procedure must require that:

304.30 (1) a staff member helps the client develop and process a grievance;

304.31 (2) current telephone numbers and addresses of the Department of Human Services,
 304.32 Licensing Division; the Office of Ombudsman for Mental Health and Developmental

305.1 Disabilities; the Department of Health Office of Health Facilities Complaints; and the Board
305.2 of Behavioral Health and Therapy, when applicable, be made available to a client; and

305.3 (3) a license holder responds to the client's grievance within three days of a staff member's
305.4 receipt of the grievance, and the client may bring the grievance to the highest level of
305.5 authority in the program if not resolved by another staff member.

305.6 Subd. 3. **Photographs of client.** (a) A photograph, video, or motion picture of a client
305.7 taken in the provision of treatment service is considered client records. A photograph for
305.8 identification and a recording by video or audio technology to enhance either therapy or
305.9 staff member supervision may be required of a client, but may only be available for use as
305.10 communications within a program. A client must be informed when the client's actions are
305.11 being recorded by camera or other technology, and the client must have the right to refuse
305.12 any recording or photography, except as authorized by this subdivision.

305.13 (b) A license holder must have a written policy regarding the use of any personal
305.14 electronic device that can record, transmit, or make images of another client. A license
305.15 holder must inform each client of this policy and the client's right to refuse being
305.16 photographed or recorded.

305.17 **EFFECTIVE DATE.** This section is effective January 1, 2018.

305.18 Sec. 24. **[245G.16] BEHAVIORAL EMERGENCY PROCEDURES.**

305.19 (a) A license holder or applicant must have written behavioral emergency procedures
305.20 that staff must follow when responding to a client who exhibits behavior that is threatening
305.21 to the safety of the client or others. Programs must incorporate person-centered planning
305.22 and trauma-informed care in the program's behavioral emergency procedure policies. The
305.23 procedures must include:

305.24 (1) a plan designed to prevent a client from hurting themselves or others;

305.25 (2) contact information for emergency resources that staff must consult when a client's
305.26 behavior cannot be controlled by the behavioral emergency procedures;

305.27 (3) types of procedures that may be used;

305.28 (4) circumstances under which behavioral emergency procedures may be used; and

305.29 (5) staff members authorized to implement behavioral emergency procedures.

305.30 (b) Behavioral emergency procedures must not be used to enforce facility rules or for
305.31 the convenience of staff. Behavioral emergency procedures must not be part of any client's
305.32 treatment plan, or used at any time for any reason except in response to specific current

306.1 behavior that threatens the safety of the client or others. Behavioral emergency procedures
306.2 may not include the use of seclusion or restraint.

306.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

306.4 Sec. 25. **[245G.17] EVALUATION.**

306.5 A license holder must participate in the drug and alcohol abuse normative evaluation
306.6 system by submitting information about each client to the commissioner in a manner
306.7 prescribed by the commissioner. A license holder must submit additional information
306.8 requested by the commissioner that is necessary to meet statutory or federal funding
306.9 requirements.

306.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

306.11 Sec. 26. **[245G.18] LICENSE HOLDERS SERVING ADOLESCENTS.**

306.12 Subdivision 1. **License.** A residential treatment program that serves an adolescent younger
306.13 than 16 years of age must be licensed as a residential program for a child in out-of-home
306.14 placement by the department unless the license holder is exempt under section 245A.03,
306.15 subdivision 2.

306.16 Subd. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements
306.17 specified in section 245G.11, subdivisions 1 and 5, an alcohol and drug counselor providing
306.18 treatment service to an adolescent must have:

306.19 (1) an additional 30 hours of classroom instruction or one three-credit semester college
306.20 course in adolescent development. This training need only be completed one time; and

306.21 (2) at least 150 hours of supervised experience as an adolescent counselor, either as a
306.22 student or as a staff member.

306.23 Subd. 3. **Staff ratios.** At least 25 percent of a counselor's scheduled work hours must
306.24 be allocated to indirect services, including documentation of client services, coordination
306.25 of services with others, treatment team meetings, and other duties. A counseling group
306.26 consisting entirely of adolescents must not exceed 16 adolescents. It is the responsibility of
306.27 the license holder to determine an acceptable group size based on the needs of the clients.

306.28 Subd. 4. **Academic program requirements.** A client who is required to attend school
306.29 must be enrolled and attending an educational program that was approved by the Department
306.30 of Education.

307.1 Subd. 5. **Program requirements.** In addition to the requirements specified in the client's
307.2 treatment plan under section 245G.06, programs serving an adolescent must include:

307.3 (1) coordination with the school system to address the client's academic needs;

307.4 (2) when appropriate, a plan that addresses the client's leisure activities without chemical
307.5 use; and

307.6 (3) a plan that addresses family involvement in the adolescent's treatment.

307.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

307.8 Sec. 27. **[245G.19] LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.**

307.9 Subdivision 1. **Health license requirements.** In addition to the requirements of sections
307.10 245G.01 to 245G.17, a license holder that offers supervision of a child of a client is subject
307.11 to the requirements of this section. A license holder providing room and board for a client
307.12 and the client's child must have an appropriate facility license from the Department of
307.13 Health.

307.14 Subd. 2. **Supervision of a child.** "Supervision of a child" means a caregiver is within
307.15 sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can
307.16 intervene to protect the child's health and safety. For a school-age child it means a caregiver
307.17 is available to help and care for the child to protect the child's health and safety.

307.18 Subd. 3. **Policy and schedule required.** A license holder must meet the following
307.19 requirements:

307.20 (1) have a policy and schedule delineating the times and circumstances when the license
307.21 holder is responsible for supervision of a child in the program and when the child's parents
307.22 are responsible for supervision of a child. The policy must explain how the program will
307.23 communicate its policy about supervision of a child responsibility to the parent; and

307.24 (2) have written procedures addressing the actions a staff member must take if a child
307.25 is neglected or abused, including while the child is under the supervision of the child's
307.26 parent.

307.27 Subd. 4. **Additional licensing requirements.** During the times the license holder is
307.28 responsible for the supervision of a child, the license holder must meet the following
307.29 standards:

307.30 (1) child and adult ratios in Minnesota Rules, part 9502.0367;

307.31 (2) day care training in section 245A.50;

308.1 (3) behavior guidance in Minnesota Rules, part 9502.0395;

308.2 (4) activities and equipment in Minnesota Rules, part 9502.0415;

308.3 (5) physical environment in Minnesota Rules, part 9502.0425; and

308.4 (6) water, food, and nutrition in Minnesota Rules, part 9502.0445, unless the license

308.5 holder has a license from the Department of Health.

308.6 **EFFECTIVE DATE.** This section is effective January 1, 2018.

308.7 **Sec. 28. [245G.20] LICENSE HOLDERS SERVING PERSONS WITH**

308.8 **CO-OCCURRING DISORDERS.**

308.9 A license holder specializing in the treatment of a person with co-occurring disorders

308.10 must:

308.11 (1) demonstrate that staff levels are appropriate for treating a client with a co-occurring

308.12 disorder, and that there are adequate staff members with mental health training;

308.13 (2) have continuing access to a medical provider with appropriate expertise in prescribing

308.14 psychotropic medication;

308.15 (3) have a mental health professional available for staff member supervision and

308.16 consultation;

308.17 (4) determine group size, structure, and content considering the special needs of a client

308.18 with a co-occurring disorder;

308.19 (5) have documentation of active interventions to stabilize mental health symptoms

308.20 present in the individual treatment plans and progress notes;

308.21 (6) have continuing documentation of collaboration with continuing care mental health

308.22 providers, and involvement of the providers in treatment planning meetings;

308.23 (7) have available program materials adapted to a client with a mental health problem;

308.24 (8) have policies that provide flexibility for a client who may lapse in treatment or may

308.25 have difficulty adhering to established treatment rules as a result of a mental illness, with

308.26 the goal of helping a client successfully complete treatment; and

308.27 (9) have individual psychotherapy and case management available during treatment

308.28 service.

308.29 **EFFECTIVE DATE.** This section is effective January 1, 2018.

309.1 Sec. 29. [245G.21] REQUIREMENTS FOR LICENSED RESIDENTIAL
309.2 TREATMENT.

309.3 Subdivision 1. **Applicability.** A license holder who provides supervised room and board
309.4 at the licensed program site as a treatment component is defined as a residential program
309.5 according to section 245A.02, subdivision 14, and is subject to this section.

309.6 Subd. 2. **Visitors.** A client must be allowed to receive visitors at times prescribed by
309.7 the license holder. The license holder must set and post a notice of visiting rules and hours,
309.8 including both day and evening times. A client's right to receive visitors other than a personal
309.9 physician, religious adviser, county case manager, parole or probation officer, or attorney
309.10 may be subject to visiting hours established by the license holder for all clients. The treatment
309.11 director or designee may impose limitations as necessary for the welfare of a client provided
309.12 the limitation and the reasons for the limitation are documented in the client's file. A client
309.13 must be allowed to receive visits at all reasonable times from the client's personal physician,
309.14 religious adviser, county case manager, parole or probation officer, and attorney.

309.15 Subd. 3. **Client property management.** A license holder who provides room and board
309.16 and treatment services to a client in the same facility, and any license holder that accepts
309.17 client property must meet the requirements for handling client funds and property in section
309.18 245A.04, subdivision 13. License holders:

309.19 (1) may establish policies regarding the use of personal property to ensure that treatment
309.20 activities and the rights of other clients are not infringed upon;

309.21 (2) may take temporary custody of a client's property for violation of a facility policy;

309.22 (3) must retain the client's property for a minimum of seven days after the client's service
309.23 termination if the client does not reclaim property upon service termination, or for a minimum
309.24 of 30 days if the client does not reclaim property upon service termination and has received
309.25 room and board services from the license holder; and

309.26 (4) must return all property held in trust to the client at service termination regardless
309.27 of the client's service termination status, except that:

309.28 (i) a drug, drug paraphernalia, or drug container that is subject to forfeiture under section
309.29 609.5316, must be given to the custody of a local law enforcement agency. If giving the
309.30 property to the custody of a local law enforcement agency violates Code of Federal
309.31 Regulations, title 42, sections 2.1 to 2.67, or title 45, parts 160 to 164, a drug, drug
309.32 paraphernalia, or drug container must be destroyed by a staff member designated by the
309.33 program director; and

310.1 (ii) a weapon, explosive, and other property that can cause serious harm to the client or
310.2 others must be given to the custody of a local law enforcement agency, and the client must
310.3 be notified of the transfer and of the client's right to reclaim any lawful property transferred;
310.4 and

310.5 (iii) a medication that was determined by a physician to be harmful after examining the
310.6 client must be destroyed, except when the client's personal physician approves the medication
310.7 for continued use.

310.8 Subd. 4. **Health facility license.** A license holder who provides room and board and
310.9 treatment services in the same facility must have the appropriate license from the Department
310.10 of Health.

310.11 Subd. 5. **Facility abuse prevention plan.** A license holder must establish and enforce
310.12 an ongoing facility abuse prevention plan consistent with sections 245A.65 and 626.557,
310.13 subdivision 14.

310.14 Subd. 6. **Individual abuse prevention plan.** A license holder must prepare an individual
310.15 abuse prevention plan for each client as specified under sections 245A.65, subdivision 2,
310.16 and 626.557, subdivision 14.

310.17 Subd. 7. **Health services.** A license holder must have written procedures for assessing
310.18 and monitoring a client's health, including a standardized data collection tool for collecting
310.19 health-related information about each client. The policies and procedures must be approved
310.20 and signed by a registered nurse.

310.21 Subd. 8. **Administration of medication.** A license holder must meet the administration
310.22 of medications requirements of section 245G.08, subdivision 5, if services include medication
310.23 administration.

310.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

310.25 Sec. 30. **[245G.22] OPIOID TREATMENT PROGRAMS.**

310.26 Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed
310.27 under this chapter must also comply with the requirements of this section and Code of
310.28 Federal Regulations, title 42, part 8. When federal guidance or interpretations are issued on
310.29 federal standards or requirements also required under this section, the federal guidance or
310.30 interpretations shall apply.

310.31 (b) Where a standard in this section differs from a standard in an otherwise applicable
310.32 administrative rule or statute, the standard of this section applies.

311.1 Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision
311.2 have the meanings given them.

311.3 (b) "Diversion" means the use of a medication for the treatment of opioid addiction being
311.4 diverted from intended use of the medication.

311.5 (c) "Guest dose" means administration of a medication used for the treatment of opioid
311.6 addiction to a person who is not a client of the program that is administering or dispensing
311.7 the medication.

311.8 (d) "Medical director" means a physician licensed to practice medicine in the jurisdiction
311.9 that the opioid treatment program is located who assumes responsibility for administering
311.10 all medical services performed by the program, either by performing the services directly
311.11 or by delegating specific responsibility to authorized program physicians and health care
311.12 professionals functioning under the medical director's direct supervision.

311.13 (e) "Medication used for the treatment of opioid use disorder" means a medication
311.14 approved by the Food and Drug Administration for the treatment of opioid use disorder.

311.15 (f) "Minnesota health care programs" has the meaning given in section 256B.0636.

311.16 (g) "Opioid treatment program" has the meaning given in Code of Federal Regulations,
311.17 title 42, section 8.12, and includes programs licensed under this chapter.

311.18 (h) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605,
311.19 subpart 21a.

311.20 (i) "Unsupervised use" means the use of a medication for the treatment of opioid use
311.21 disorder dispensed for use by a client outside of the program setting.

311.22 Subd. 3. **Medication orders.** Before the program may administer or dispense a medication
311.23 used for the treatment of opioid use disorder:

311.24 (1) a client-specific order must be received from an appropriately credentialed physician
311.25 who is enrolled as a Minnesota health care programs provider and meets all applicable
311.26 provider standards;

311.27 (2) the signed order must be documented in the client's record; and

311.28 (3) if the physician that issued the order is not able to sign the order when issued, the
311.29 unsigned order must be entered in the client record at the time it was received, and the
311.30 physician must review the documentation and sign the order in the client's record within 72
311.31 hours of the medication being ordered. The license holder must report to the commissioner
311.32 any medication error that endangers a client's health, as determined by the medical director.

312.1 Subd. 4. **High dose requirements.** A client being administered or dispensed a dose
312.2 beyond that set forth in subdivision 6, paragraph (a), clause (1), that exceeds 150 milligrams
312.3 of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase,
312.4 must meet face-to-face with a prescribing physician. The meeting must occur before the
312.5 administration or dispensing of the increased medication dose.

312.6 Subd. 5. **Drug testing.** Each client enrolled in the program must receive a minimum of
312.7 eight random drug abuse tests per 12 months of treatment. Drug abuse tests must be
312.8 reasonably disbursed over the 12-month period. A license holder may elect to conduct more
312.9 drug abuse tests.

312.10 Subd. 6. **Criteria for unsupervised use.** (a) To limit the potential for diversion of
312.11 medication used for the treatment of opioid use disorder to the illicit market, medication
312.12 dispensed to a client for unsupervised use shall be subject to the following requirements:

312.13 (1) any client in an opioid treatment program may receive a single unsupervised use
312.14 dose for a day that the clinic is closed for business, including Sundays and state and federal
312.15 holidays; and

312.16 (2) other treatment program decisions on dispensing medications used for the treatment
312.17 of opioid use disorder to a client for unsupervised use shall be determined by the medical
312.18 director.

312.19 (b) In determining whether a client may be permitted unsupervised use of medications,
312.20 a physician with authority to prescribe must consider the criteria in this paragraph. The
312.21 criteria in this paragraph must also be considered when determining whether dispensing
312.22 medication for a client's unsupervised use is appropriate to increase or to extend the amount
312.23 of time between visits to the program. The criteria are:

312.24 (1) absence of recent abuse of drugs including but not limited to opioids, non-narcotics,
312.25 and alcohol;

312.26 (2) regularity of program attendance;

312.27 (3) absence of serious behavioral problems at the program;

312.28 (4) absence of known recent criminal activity such as drug dealing;

312.29 (5) stability of the client's home environment and social relationships;

312.30 (6) length of time in comprehensive maintenance treatment;

312.31 (7) reasonable assurance that unsupervised use medication will be safely stored within
312.32 the client's home; and

313.1 (8) whether the rehabilitative benefit the client derived from decreasing the frequency
313.2 of program attendance outweighs the potential risks of diversion or unsupervised use.

313.3 (c) The determination, including the basis of the determination must be documented in
313.4 the client's medical record.

313.5 Subd. 7. **Restrictions for unsupervised use of methadone hydrochloride.** (a) If a
313.6 physician with authority to prescribe determines that a client meets the criteria in subdivision
313.7 6 and may be dispensed a medication used for the treatment of opioid addiction, the
313.8 restrictions in this subdivision must be followed when the medication to be dispensed is
313.9 methadone hydrochloride.

313.10 (b) During the first 90 days of treatment, the unsupervised use medication supply must
313.11 be limited to a maximum of a single dose each week and the client shall ingest all other
313.12 doses under direct supervision.

313.13 (c) In the second 90 days of treatment, the unsupervised use medication supply must be
313.14 limited to two doses per week.

313.15 (d) In the third 90 days of treatment, the unsupervised use medication supply must not
313.16 exceed three doses per week.

313.17 (e) In the remaining months of the first year, a client may be given a maximum six-day
313.18 unsupervised use medication supply.

313.19 (f) After one year of continuous treatment, a client may be given a maximum two-week
313.20 unsupervised use medication supply.

313.21 (g) After two years of continuous treatment, a client may be given a maximum one-month
313.22 unsupervised use medication supply, but must make monthly visits to the program.

313.23 Subd. 8. **Restriction exceptions.** When a license holder has reason to accelerate the
313.24 number of unsupervised use doses of methadone hydrochloride, the license holder must
313.25 comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the
313.26 criteria for unsupervised use and must use the exception process provided by the federal
313.27 Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the
313.28 purposes of enforcement of this subdivision, the commissioner has the authority to monitor
313.29 a program for compliance with federal regulations and may issue licensing actions according
313.30 to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of
313.31 noncompliance.

313.32 Subd. 9. **Guest dose.** To receive a guest dose, the client must be enrolled in an opioid
313.33 treatment program elsewhere in the state or country and be receiving the medication on a

314.1 temporary basis because the client is not able to receive the medication at the program in
314.2 which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any
314.3 one program and must not be for the convenience or benefit of either program. A guest dose
314.4 may also occur when the client's primary clinic is not open and the client is not receiving
314.5 unsupervised use doses.

314.6 Subd. 10. **Capacity management and waiting list system compliance.** An opioid
314.7 treatment program must notify the department within seven days of the program reaching
314.8 both 90 and 100 percent of the program's capacity to care for clients. Each week, the program
314.9 must report its capacity, currently enrolled dosing clients, and any waiting list. A program
314.10 reporting 90 percent of capacity must also notify the department when the program's census
314.11 increases or decreases from the 90 percent level.

314.12 Subd. 11. **Waiting list.** An opioid treatment program must have a waiting list system.
314.13 If the person seeking admission cannot be admitted within 14 days of the date of application,
314.14 each person seeking admission must be placed on the waiting list, unless the person seeking
314.15 admission is assessed by the program and found ineligible for admission according to this
314.16 chapter and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and
314.17 title 45, parts 160 to 164. The waiting list must assign a unique client identifier for each
314.18 person seeking treatment while awaiting admission. A person seeking admission on a waiting
314.19 list who receives no services under section 245G.07, subdivision 1, must not be considered
314.20 a client as defined in section 245G.01, subdivision 9.

314.21 Subd. 12. **Client referral.** An opioid treatment program must consult the capacity
314.22 management system to ensure that a person on a waiting list is admitted at the earliest time
314.23 to a program providing appropriate treatment within a reasonable geographic area. If the
314.24 client was referred through a public payment system and if the program is not able to serve
314.25 the client within 14 days of the date of application for admission, the program must contact
314.26 and inform the referring agency of any available treatment capacity listed in the state capacity
314.27 management system.

314.28 Subd. 13. **Outreach.** An opioid treatment program must carry out activities to encourage
314.29 an individual in need of treatment to undergo treatment. The program's outreach model
314.30 must:

314.31 (1) select, train, and supervise outreach workers;

314.32 (2) contact, communicate, and follow up with individuals with high-risk substance
314.33 misuse, individuals with high-risk substance misuse associates, and neighborhood residents
314.34 within the constraints of federal and state confidentiality requirements;

315.1 (3) promote awareness among individuals who engage in substance misuse by injection
315.2 about the relationship between injecting substances and communicable diseases such as
315.3 HIV; and

315.4 (4) recommend steps to prevent HIV transmission.

315.5 Subd. 14. **Central registry.** (a) A license holder must comply with requirements to
315.6 submit information and necessary consents to the state central registry for each client
315.7 admitted, as specified by the commissioner. The license holder must submit data concerning
315.8 medication used for the treatment of opioid use disorder. The data must be submitted in a
315.9 method determined by the commissioner and the original information must be kept in the
315.10 client's record. The information must be submitted for each client at admission and discharge.
315.11 The program must document the date the information was submitted. The client's failure to
315.12 provide the information shall prohibit participation in an opioid treatment program. The
315.13 information submitted must include the client's:

315.14 (1) full name and all aliases;

315.15 (2) date of admission;

315.16 (3) date of birth;

315.17 (4) Social Security number or Alien Registration Number, if any;

315.18 (5) current or previous enrollment status in another opioid treatment program;

315.19 (6) government-issued photo identification card number; and

315.20 (7) driver's license number, if any.

315.21 (b) The requirements in paragraph (a) are effective upon the commissioner's
315.22 implementation of changes to the drug and alcohol abuse normative evaluation system or
315.23 development of an electronic system by which to submit the data.

315.24 Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must
315.25 offer at least 50 consecutive minutes of individual or group therapy treatment services as
315.26 defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first
315.27 ten weeks following admission, and at least 50 consecutive minutes per month thereafter.
315.28 As clinically appropriate, the program may offer these services cumulatively and not
315.29 consecutively in increments of no less than 15 minutes over the required time period, and
315.30 for a total of 60 minutes of treatment services over the time period, and must document the
315.31 reason for providing services cumulatively in the client's record. The program may offer
315.32 additional levels of service when deemed clinically necessary.

316.1 (b) Notwithstanding the requirements of comprehensive assessments in section 245G.05,
316.2 the assessment must be completed within 21 days of service initiation.

316.3 (c) Notwithstanding the requirements of individual treatment plans set forth in section
316.4 245G.06:

316.5 (1) treatment plan contents for a maintenance client are not required to include goals
316.6 the client must reach to complete treatment and have services terminated;

316.7 (2) treatment plans for a client in a taper or detox status must include goals the client
316.8 must reach to complete treatment and have services terminated;

316.9 (3) for the initial ten weeks after admission for all new admissions, readmissions, and
316.10 transfers, progress notes must be entered in a client's file at least weekly and be recorded
316.11 in each of the six dimensions upon the development of the treatment plan and thereafter.
316.12 Subsequently, the counselor must document progress in the six dimensions at least once
316.13 monthly or, when clinical need warrants, more frequently; and

316.14 (4) upon the development of the treatment plan and thereafter, treatment plan reviews
316.15 must occur weekly, or after each treatment service, whichever is less frequent, for the first
316.16 ten weeks after the treatment plan is developed. Following the first ten weeks of treatment
316.17 plan reviews, reviews may occur monthly, unless the client's needs warrant more frequent
316.18 revisions or documentation.

316.19 Subd. 16. **Prescription monitoring program.** (a) The program must develop and
316.20 maintain a policy and procedure that requires the ongoing monitoring of the data from the
316.21 prescription monitoring program (PMP) for each client. The policy and procedure must
316.22 include how the program meets the requirements in paragraph (b).

316.23 (b) If a medication used for the treatment of substance use disorder is administered or
316.24 dispensed to a client, the license holder shall be subject to the following requirements:

316.25 (1) upon admission to a methadone clinic outpatient treatment program, a client must
316.26 be notified in writing that the commissioner of human services and the medical director
316.27 must monitor the PMP to review the prescribed controlled drugs a client received;

316.28 (2) the medical director or the medical director's delegate must review the data from the
316.29 PMP described in section 152.126 before the client is ordered any controlled substance, as
316.30 defined under section 152.126, subdivision 1, paragraph (c), including medications used
316.31 for the treatment of opioid addiction, and the medical director's or the medical director's
316.32 delegate's subsequent reviews of the PMP data must occur at least every 90 days;

316.33 (3) a copy of the PMP data reviewed must be maintained in the client's file;

317.1 (4) when the PMP data contains a recent history of multiple prescribers or multiple
317.2 prescriptions for controlled substances, the physician's review of the data and subsequent
317.3 actions must be documented in the client's file within 72 hours and must contain the medical
317.4 director's determination of whether or not the prescriptions place the client at risk of harm
317.5 and the actions to be taken in response to the PMP findings. The provider must conduct
317.6 subsequent reviews of the PMP on a monthly basis; and

317.7 (5) if at any time the medical director believes the use of the controlled substances places
317.8 the client at risk of harm, the program must seek the client's consent to discuss the client's
317.9 opioid treatment with other prescribers and must seek the client's consent for the other
317.10 prescriber to disclose to the opioid treatment program's medical director the client's condition
317.11 that formed the basis of the other prescriptions. If the information is not obtained within
317.12 seven days, the medical director must document whether or not changes to the client's
317.13 medication dose or number of unsupervised use doses are necessary until the information
317.14 is obtained.

317.15 (c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop
317.16 and implement an electronic system for the commissioner to routinely access the PMP data
317.17 to determine whether any client enrolled in an opioid addiction treatment program licensed
317.18 according to this section was prescribed or dispensed a controlled substance in addition to
317.19 that administered or dispensed by the opioid addiction treatment program. When the
317.20 commissioner determines there have been multiple prescribers or multiple prescriptions of
317.21 controlled substances for a client, the commissioner shall:

317.22 (1) inform the medical director of the opioid treatment program only that the
317.23 commissioner determined the existence of multiple prescribers or multiple prescriptions of
317.24 controlled substances; and

317.25 (2) direct the medical director of the opioid treatment program to access the data directly,
317.26 review the effect of the multiple prescribers or multiple prescriptions, and document the
317.27 review.

317.28 (d) If determined necessary, the commissioner shall seek a federal waiver of, or exception
317.29 to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), before
317.30 implementing this subdivision.

317.31 Subd. 17. **Policies and procedures.** (a) A license holder must develop and maintain the
317.32 policies and procedures required in this subdivision.

317.33 (b) For a program that is not open every day of the year, the license holder must maintain
317.34 a policy and procedure that permits a client to receive a single unsupervised use of medication

318.1 used for the treatment of opioid use disorder for days that the program is closed for business,
318.2 including, but not limited to, Sundays and state and federal holidays as required under
318.3 subdivision 6, paragraph (a), clause (1).

318.4 (c) The license holder must maintain a policy and procedure that includes specific
318.5 measures to reduce the possibility of diversion. The policy and procedure must:

318.6 (1) specifically identify and define the responsibilities of the medical and administrative
318.7 staff for performing diversion control measures; and

318.8 (2) include a process for contacting no less than five percent of clients who have
318.9 unsupervised use of medication, excluding clients approved solely under subdivision 6,
318.10 paragraph (a), clause (1), to require clients to physically return to the program each month.
318.11 The system must require clients to return to the program within a stipulated time frame and
318.12 turn in all unused medication containers related to opioid use disorder treatment. The license
318.13 holder must document all related contacts on a central log and the outcome of the contact
318.14 for each client in the client's record.

318.15 (d) Medication used for the treatment of opioid use disorder must be ordered,
318.16 administered, and dispensed according to applicable state and federal regulations and the
318.17 standards set by applicable accreditation entities. If a medication order requires assessment
318.18 by the person administering or dispensing the medication to determine the amount to be
318.19 administered or dispensed, the assessment must be completed by an individual whose
318.20 professional scope of practice permits an assessment. For the purposes of enforcement of
318.21 this paragraph, the commissioner has the authority to monitor the person administering or
318.22 dispensing the medication for compliance with state and federal regulations and the relevant
318.23 standards of the license holder's accreditation agency and may issue licensing actions
318.24 according to sections 245A.05, 245A.06, and 245A.07, based on the commissioner's
318.25 determination of noncompliance.

318.26 Subd. 18. **Quality improvement plan.** The license holder must develop and maintain
318.27 a quality improvement plan that:

318.28 (1) includes evaluation of the services provided to clients to identify issues that may
318.29 improve service delivery and client outcomes;

318.30 (2) includes goals for the program to accomplish based on the evaluation;

318.31 (3) is reviewed annually by the management of the program to determine whether the
318.32 goals were met and, if not, whether additional action is required;

319.1 (4) is updated at least annually to include new or continued goals based on an updated
319.2 evaluation of services; and

319.3 (5) identifies two specific goal areas, in addition to others identified by the program,
319.4 including:

319.5 (i) a goal concerning oversight and monitoring of the premises around and near the
319.6 exterior of the program to reduce the possibility of medication used for the treatment of
319.7 opioid use disorder being inappropriately used by a client, including but not limited to the
319.8 sale or transfer of the medication to others; and

319.9 (ii) a goal concerning community outreach, including but not limited to communications
319.10 with local law enforcement and county human services agencies, to increase coordination
319.11 of services and identification of areas of concern to be addressed in the plan.

319.12 Subd. 19. **Placing authorities.** A program must provide certain notification and
319.13 client-specific updates to placing authorities for a client who is enrolled in Minnesota health
319.14 care programs. At the request of the placing authority, the program must provide
319.15 client-specific updates, including but not limited to informing the placing authority of
319.16 positive drug screenings and changes in medications used for the treatment of opioid use
319.17 disorder ordered for the client.

319.18 Subd. 20. **Duty to report suspected drug diversion.** (a) To the fullest extent permitted
319.19 under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to
319.20 law enforcement any credible evidence that the program or its personnel knows, or reasonably
319.21 should know, that is directly related to a diversion crime on the premises of the program,
319.22 or a threat to commit a diversion crime.

319.23 (b) "Diversion crime," for the purposes of this section, means diverting, attempting to
319.24 divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02,
319.25 on the program's premises.

319.26 (c) The program must document the program's compliance with the requirement in
319.27 paragraph (a) in either a client's record or an incident report. A program's failure to comply
319.28 with paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

319.29 **EFFECTIVE DATE.** This section is effective July 1, 2017.

319.30 Sec. 31. Minnesota Statutes 2016, section 246.18, subdivision 4, is amended to read:

319.31 Subd. 4. **Collections deposited in the general fund.** Except as provided in subdivisions
319.32 5, 6, and 7, all receipts from collection efforts for the regional treatment centers, state nursing

320.1 homes; and other state facilities as defined in section 246.50, subdivision 3, must be deposited
 320.2 in the general fund. From that amount, receipts from collection efforts for regional treatment
 320.3 centers and community behavioral health hospitals must be deposited in accordance with
 320.4 subdivision 4a. The commissioner shall ensure that the departmental financial reporting
 320.5 systems and internal accounting procedures comply with federal standards for reimbursement
 320.6 for program and administrative expenditures and fulfill the purpose of this ~~paragraph~~
 320.7 subdivision.

320.8 Sec. 32. Minnesota Statutes 2016, section 246.18, is amended by adding a subdivision to
 320.9 read:

320.10 Subd. 4a. **Mental health innovation account.** The mental health innovation account is
 320.11 established in the special revenue fund. In fiscal year 2018 and fiscal year 2019, \$2,000,000
 320.12 of the revenue generated by collection efforts from the regional treatment centers and
 320.13 community behavioral health hospitals under section 246.54 must be deposited into the
 320.14 mental health innovation account. Beginning in fiscal year 2020, \$2,500,000 of the revenue
 320.15 generated by collection efforts from the regional treatment centers and community behavioral
 320.16 health hospitals under section 246.54 must annually be deposited into the mental health
 320.17 innovation account. Money deposited in the mental health innovation account is appropriated
 320.18 to the commissioner of human services for the mental health innovation grant program
 320.19 under section 245.4662.

320.20 Sec. 33. Minnesota Statutes 2016, section 254A.01, is amended to read:

320.21 **254A.01 PUBLIC POLICY.**

320.22 It is hereby declared to be the public policy of this state that scientific evidence shows
 320.23 that addiction to alcohol or other drugs is a chronic brain disorder with potential for
 320.24 recurrence, and as with many other chronic conditions, people with substance use disorders
 320.25 can be effectively treated and can enter recovery. The interests of society are best served
 320.26 by reducing the stigma of substance use disorder and providing persons who are dependent
 320.27 upon alcohol or other drugs with a comprehensive range of rehabilitative and social services
 320.28 that span intensity levels and are not restricted to a particular point in time. Further, it is
 320.29 declared that treatment under these services shall be voluntary when possible: treatment
 320.30 shall not be denied on the basis of prior treatment; treatment shall be based on an individual
 320.31 treatment plan for each person undergoing treatment; treatment shall include a continuum
 320.32 of services available for a person leaving a program of treatment; treatment shall include
 320.33 all family members at the earliest possible phase of the treatment process.

321.1 **EFFECTIVE DATE.** This section is effective January 1, 2018.

321.2 Sec. 34. Minnesota Statutes 2016, section 254A.02, subdivision 2, is amended to read:

321.3 Subd. 2. **Approved treatment program.** "Approved treatment program" means care
321.4 and treatment services provided by any individual, organization or association to ~~drug~~
321.5 ~~dependent persons~~ with a substance use disorder, which meets the standards established by
321.6 the commissioner of human services.

321.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

321.8 Sec. 35. Minnesota Statutes 2016, section 254A.02, subdivision 3, is amended to read:

321.9 Subd. 3. **Comprehensive program.** "Comprehensive program" means the range of
321.10 services which are to be made available for the purpose of prevention, care and treatment
321.11 of ~~alcohol and drug abuse~~ substance misuse and substance use disorder.

321.12 **EFFECTIVE DATE.** This section is effective January 1, 2018.

321.13 Sec. 36. Minnesota Statutes 2016, section 254A.02, subdivision 5, is amended to read:

321.14 Subd. 5. **Drug dependent person.** "Drug dependent person" means any ~~inebriate person~~
321.15 ~~or any~~ person incapable of self-management or management of personal affairs or unable
321.16 to function physically or mentally in an effective manner because of the abuse of a drug,
321.17 including alcohol.

321.18 **EFFECTIVE DATE.** This section is effective January 1, 2018.

321.19 Sec. 37. Minnesota Statutes 2016, section 254A.02, subdivision 6, is amended to read:

321.20 Subd. 6. **Facility.** "Facility" means any treatment facility administered under an approved
321.21 treatment program ~~established under Laws 1973, chapter 572.~~

321.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

321.23 Sec. 38. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision
321.24 to read:

321.25 Subd. 6a. **Substance misuse.** "Substance misuse" means the use of any psychoactive
321.26 or mood-altering substance, without compelling medical reason, in a manner that results in
321.27 mental, emotional, or physical impairment and causes socially dysfunctional or socially
321.28 disordering behavior and that results in psychological dependence or physiological addiction

322.1 as a function of continued use. Substance misuse has the same meaning as drug abuse or
322.2 abuse of drugs.

322.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

322.4 Sec. 39. Minnesota Statutes 2016, section 254A.02, subdivision 8, is amended to read:

322.5 Subd. 8. **Other drugs.** "Other drugs" means any psychoactive ~~chemical~~ substance other
322.6 than alcohol.

322.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

322.8 Sec. 40. Minnesota Statutes 2016, section 254A.02, subdivision 10, is amended to read:

322.9 Subd. 10. **State authority.** "State authority" is a division established within the
322.10 Department of Human Services for the purpose of relating the authority of state government
322.11 in the area of ~~alcohol and drug abuse~~ substance misuse and substance use disorder to the
322.12 ~~alcohol and drug abuse~~ substance misuse and substance use disorder-related activities within
322.13 the state.

322.14 **EFFECTIVE DATE.** This section is effective January 1, 2018.

322.15 Sec. 41. Minnesota Statutes 2016, section 254A.02, is amended by adding a subdivision
322.16 to read:

322.17 Subd. 10a. **Substance use disorder.** "Substance use disorder" has the meaning given
322.18 in the current Diagnostic and Statistical Manual of Mental Disorders.

322.19 **EFFECTIVE DATE.** This section is effective January 1, 2018.

322.20 Sec. 42. Minnesota Statutes 2016, section 254A.03, is amended to read:

322.21 **254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.**

322.22 Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an
322.23 Alcohol and Other Drug Abuse Section in the Department of Human Services. This section
322.24 shall be headed by a director. The commissioner may place the director's position in the
322.25 unclassified service if the position meets the criteria established in section 43A.08,
322.26 subdivision 1a. The section shall:

322.27 (1) conduct and foster basic research relating to the cause, prevention and methods of
322.28 diagnosis, treatment and rehabilitation of ~~alcoholic and other drug dependent~~ persons with
322.29 substance misuse and substance use disorder;

323.1 (2) coordinate and review all activities and programs of all the various state departments
 323.2 as they relate to ~~alcohol and other drug dependency and abuse~~ problems associated with
 323.3 substance misuse and substance use disorder;

323.4 (3) develop, demonstrate, and disseminate new methods and techniques for ~~the~~ prevention,
 323.5 early intervention, treatment and ~~rehabilitation of alcohol and other drug abuse and~~
 323.6 ~~dependency problems~~ recovery support for substance misuse and substance use disorder;

323.7 (4) gather facts and information about ~~alcoholism and other drug dependency and abuse~~
 323.8 substance misuse and substance use disorder, and about the efficiency and effectiveness of
 323.9 prevention, treatment, and ~~rehabilitation~~ recovery support services from all comprehensive
 323.10 programs, including programs approved or licensed by the commissioner of human services
 323.11 or the commissioner of health or accredited by the Joint Commission on Accreditation of
 323.12 Hospitals. The state authority is authorized to require information from comprehensive
 323.13 programs which is reasonable and necessary to fulfill these duties. When required information
 323.14 has been previously furnished to a state or local governmental agency, the state authority
 323.15 shall collect the information from the governmental agency. The state authority shall
 323.16 disseminate facts and summary information about ~~alcohol and other drug abuse dependency~~
 323.17 ~~problems~~ associated with substance misuse and substance use disorder to public and private
 323.18 agencies, local governments, local and regional planning agencies, and the courts for guidance
 323.19 to and assistance in prevention, treatment and ~~rehabilitation~~ recovery support;

323.20 (5) inform and educate the general public on ~~alcohol and other drug dependency and~~
 323.21 ~~abuse problems~~ substance misuse and substance use disorder;

323.22 (6) serve as the state authority concerning ~~alcohol and other drug dependency and abuse~~
 323.23 substance misuse and substance use disorder by monitoring the conduct of diagnosis and
 323.24 referral services, research and comprehensive programs. The state authority shall submit a
 323.25 biennial report to the governor and the legislature containing a description of public services
 323.26 delivery and recommendations concerning increase of coordination and quality of services,
 323.27 and decrease of service duplication and cost;

323.28 (7) establish a state plan which shall set forth goals and priorities for a comprehensive
 323.29 ~~alcohol and other drug dependency and abuse program~~ continuum of care for substance
 323.30 misuse and substance use disorder for Minnesota. All state agencies operating ~~alcohol and~~
 323.31 ~~other drug abuse or dependency~~ substance misuse or substance use disorder programs or
 323.32 administering state or federal funds for such programs shall annually set their program goals
 323.33 and priorities in accordance with the state plan. Each state agency shall annually submit its
 323.34 plans and budgets to the state authority for review. The state authority shall certify whether

324.1 proposed services comply with the comprehensive state plan and advise each state agency
324.2 of review findings;

324.3 (8) make contracts with and grants to public and private agencies and organizations,
324.4 both profit and nonprofit, and individuals, using federal funds, and state funds as authorized
324.5 to pay for costs of state administration, including evaluation, statewide programs and services,
324.6 research and demonstration projects, and American Indian programs;

324.7 (9) receive and administer ~~monies~~ money available for ~~alcohol and drug abuse~~ substance
324.8 misuse and substance use disorder programs under the alcohol, drug abuse, and mental
324.9 health services block grant, United States Code, title 42, sections 300X to 300X-9;

324.10 (10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter
324.11 572, and any grant of money, services, or property from the federal government, the state,
324.12 any political subdivision thereof, or any private source;

324.13 (11) with respect to ~~alcohol and other drug abuse~~ substance misuse and substance use
324.14 disorder programs serving the American Indian community, establish guidelines for the
324.15 employment of personnel with considerable practical experience in ~~alcohol and other drug~~
324.16 ~~abuse problems~~ substance misuse and substance use disorder, and understanding of social
324.17 and cultural problems related to ~~alcohol and other drug abuse~~ substance misuse and substance
324.18 use disorder, in the American Indian community.

324.19 Subd. 2. **American Indian programs.** There is hereby created a section of American
324.20 Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human
324.21 Services, to be headed by a special assistant for American Indian programs on ~~alcoholism~~
324.22 ~~and drug abuse~~ substance misuse and substance use disorder and two assistants to that
324.23 position. The section shall be staffed with all personnel necessary to fully administer
324.24 programming for ~~alcohol and drug abuse~~ substance misuse and substance use disorder
324.25 services for American Indians in the state. The special assistant position shall be filled by
324.26 a person with considerable practical experience in and understanding of ~~alcohol and other~~
324.27 ~~drug abuse problems~~ substance misuse and substance use disorder in the American Indian
324.28 community, who shall be responsible to the director of the Alcohol and Drug Abuse Section
324.29 created in subdivision 1 and shall be in the unclassified service. The special assistant shall
324.30 meet and consult with the American Indian Advisory Council as described in section
324.31 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report
324.32 on the status of ~~alcohol and other drug abuse~~ substance misuse and substance use disorder
324.33 among American Indians in the state of Minnesota. The special assistant with the approval
324.34 of the director shall:

325.1 (1) administer funds appropriated for American Indian groups, organizations and
 325.2 reservations within the state for American Indian ~~alcoholism and drug abuse~~ substance
 325.3 misuse and substance use disorder programs;

325.4 (2) establish policies and procedures for such American Indian programs with the
 325.5 assistance of the American Indian Advisory Board; and

325.6 (3) hire and supervise staff to assist in the administration of the American Indian program
 325.7 section within the Alcohol and Drug Abuse Section of the Department of Human Services.

325.8 Subd. 3. **Rules for ~~chemical dependency~~ substance use disorder care.** (a) The
 325.9 commissioner of human services shall establish by rule criteria to be used in determining
 325.10 the appropriate level of chemical dependency care for each recipient of public assistance
 325.11 seeking treatment for ~~alcohol or other drug dependency and abuse problems.~~ substance
 325.12 misuse or substance use disorder. Upon federal approval of a comprehensive assessment
 325.13 as a Medicaid benefit, or on July 1, 2018, whichever is later, and notwithstanding the criteria
 325.14 in Minnesota Rules, parts 9530.6600 to 9530.6655, an eligible vendor of comprehensive
 325.15 assessments under section 254B.05 may determine and approve the appropriate level of
 325.16 substance use disorder treatment for a recipient of public assistance. The process for
 325.17 determining an individual's financial eligibility for the consolidated chemical dependency
 325.18 treatment fund or determining an individual's enrollment in or eligibility for a publicly
 325.19 subsidized health plan is not affected by the individual's choice to access a comprehensive
 325.20 assessment for placement.

325.21 (b) The commissioner shall develop and implement a utilization review process for
 325.22 publicly funded treatment placements to monitor and review the clinical appropriateness
 325.23 and timeliness of all publicly funded placements in treatment.

325.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

325.25 Sec. 43. Minnesota Statutes 2016, section 254A.035, subdivision 1, is amended to read:

325.26 Subdivision 1. **Establishment.** There is created an American Indian Advisory Council
 325.27 to assist the state authority on ~~alcohol and drug abuse~~ substance misuse and substance use
 325.28 disorder in proposal review and formulating policies and procedures relating to ~~chemical~~
 325.29 ~~dependency and the abuse of alcohol and other drugs~~ substance misuse and substance use
 325.30 disorder by American Indians.

325.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

326.1 Sec. 44. Minnesota Statutes 2016, section 254A.04, is amended to read:

326.2 **254A.04 CITIZENS ADVISORY COUNCIL.**

326.3 There is hereby created an Alcohol and Other Drug Abuse Advisory Council to advise
 326.4 the Department of Human Services concerning the problems of ~~alcohol and other drug~~
 326.5 ~~dependency and abuse~~ substance misuse and substance use disorder, composed of ten
 326.6 members. Five members shall be individuals whose interests or training are in the field of
 326.7 ~~alcohol dependency~~ alcohol-specific substance use disorder and ~~abuse~~ alcohol misuse; and
 326.8 five members whose interests or training are in the field of ~~dependency~~ substance use
 326.9 disorder and ~~abuse of drugs~~ misuse of substances other than alcohol. The terms, compensation
 326.10 and removal of members shall be as provided in section 15.059. The council expires June
 326.11 30, 2018. The commissioner of human services shall appoint members whose terms end in
 326.12 even-numbered years. The commissioner of health shall appoint members whose terms end
 326.13 in odd-numbered years.

326.14 **EFFECTIVE DATE.** This section is effective January 1, 2018.

326.15 Sec. 45. Minnesota Statutes 2016, section 254A.08, is amended to read:

326.16 **254A.08 DETOXIFICATION CENTERS.**

326.17 Subdivision 1. **Detoxification services.** Every county board shall provide detoxification
 326.18 services for ~~drug-dependent persons~~ any person incapable of self-management or management
 326.19 of personal affairs or unable to function physically or mentally in an effective manner
 326.20 because of the use of a drug, including alcohol. The board may utilize existing treatment
 326.21 programs and other agencies to meet this responsibility.

326.22 Subd. 2. **Program requirements.** For the purpose of this section, a detoxification
 326.23 program means a social rehabilitation program licensed by the Department of Human
 326.24 Services under chapter 245A, and governed by the standards of Minnesota Rules, parts
 326.25 9530.6510 to 9530.6590, and established for the purpose of facilitating access into care and
 326.26 treatment by detoxifying and evaluating the person and providing entrance into a
 326.27 comprehensive program. Evaluation of the person shall include verification by a professional,
 326.28 after preliminary examination, that the person is intoxicated or has symptoms of ~~chemical~~
 326.29 ~~dependency~~ substance misuse or substance use disorder and appears to be in imminent
 326.30 danger of harming self or others. A detoxification program shall have available the services
 326.31 of a licensed physician for medical emergencies and routine medical surveillance. A
 326.32 detoxification program licensed by the Department of Human Services to serve both adults
 326.33 and minors at the same site must provide for separate sleeping areas for adults and minors.

327.1 **EFFECTIVE DATE.** This section is effective January 1, 2018.

327.2 Sec. 46. Minnesota Statutes 2016, section 254A.09, is amended to read:

327.3 **254A.09 CONFIDENTIALITY OF RECORDS.**

327.4 The Department of Human Services shall assure confidentiality to individuals who are
 327.5 the subject of research by the state authority or are recipients of ~~alcohol or drug abuse~~
 327.6 substance misuse or substance use disorder information, assessment, or treatment from a
 327.7 licensed or approved program. The commissioner shall withhold from all persons not
 327.8 connected with the conduct of the research the names or other identifying characteristics
 327.9 of a subject of research unless the individual gives written permission that information
 327.10 relative to treatment and recovery may be released. Persons authorized to protect the privacy
 327.11 of subjects of research may not be compelled in any federal, state or local, civil, criminal,
 327.12 administrative or other proceeding to identify or disclose other confidential information
 327.13 about the individuals. Identifying information and other confidential information related to
 327.14 ~~alcohol or drug abuse~~ substance misuse or substance use disorder information, assessment,
 327.15 treatment, or aftercare services may be ordered to be released by the court for the purpose
 327.16 of civil or criminal investigations or proceedings if, after review of the records considered
 327.17 for disclosure, the court determines that the information is relevant to the purpose for which
 327.18 disclosure is requested. The court shall order disclosure of only that information which is
 327.19 determined relevant. In determining whether to compel disclosure, the court shall weigh
 327.20 the public interest and the need for disclosure against the injury to the patient, to the treatment
 327.21 relationship in the program affected and in other programs similarly situated, and the actual
 327.22 or potential harm to the ability of programs to attract and retain patients if disclosure occurs.
 327.23 This section does not exempt any person from the reporting obligations under section
 327.24 626.556, nor limit the use of information reported in any proceeding arising out of the abuse
 327.25 or neglect of a child. Identifying information and other confidential information related to
 327.26 ~~alcohol or drug abuse information~~ substance misuse or substance use disorder, assessment,
 327.27 treatment, or aftercare services may be ordered to be released by the court for the purpose
 327.28 of civil or criminal investigations or proceedings. No information may be released pursuant
 327.29 to this section that would not be released pursuant to section 595.02, subdivision 2.

327.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

327.31 Sec. 47. Minnesota Statutes 2016, section 254A.19, subdivision 3, is amended to read:

327.32 Subd. 3. **Financial conflicts of interest.** (a) Except as provided in paragraph (b) ~~or~~ (c),
 327.33 or (d), an assessor conducting a chemical use assessment under Minnesota Rules, parts

328.1 9530.6600 to 9530.6655, may not have any direct or shared financial interest or referral
 328.2 relationship resulting in shared financial gain with a treatment provider.

328.3 (b) A county may contract with an assessor having a conflict described in paragraph (a)
 328.4 if the county documents that:

328.5 (1) the assessor is employed by a culturally specific service provider or a service provider
 328.6 with a program designed to treat individuals of a specific age, sex, or sexual preference;

328.7 (2) the county does not employ a sufficient number of qualified assessors and the only
 328.8 qualified assessors available in the county have a direct or shared financial interest or a
 328.9 referral relationship resulting in shared financial gain with a treatment provider; or

328.10 (3) the county social service agency has an existing relationship with an assessor or
 328.11 service provider and elects to enter into a contract with that assessor to provide both
 328.12 assessment and treatment under circumstances specified in the county's contract, provided
 328.13 the county retains responsibility for making placement decisions.

328.14 (c) The county may contract with a hospital to conduct chemical assessments if the
 328.15 requirements in subdivision 1a are met.

328.16 An assessor under this paragraph may not place clients in treatment. The assessor shall
 328.17 gather required information and provide it to the county along with any required
 328.18 documentation. The county shall make all placement decisions for clients assessed by
 328.19 assessors under this paragraph.

328.20 (d) An eligible vendor under section 254B.05 conducting a comprehensive assessment
 328.21 for an individual seeking treatment shall approve the nature, intensity level, and duration
 328.22 of treatment service if a need for services is indicated, but the individual assessed can access
 328.23 any enrolled provider that is licensed to provide the level of service authorized, including
 328.24 the provider or program that completed the assessment. If an individual is enrolled in a
 328.25 prepaid health plan, the individual must comply with any provider network requirements
 328.26 or limitations.

328.27 **EFFECTIVE DATE.** This section is effective January 1, 2018.

328.28 Sec. 48. Minnesota Statutes 2016, section 254B.01, subdivision 3, is amended to read:

328.29 Subd. 3. ~~Chemical dependency~~ **Substance use disorder treatment services.** "~~Chemical~~
 328.30 ~~dependency~~ Substance use disorder treatment services" means a planned program of care
 328.31 for the treatment of ~~chemical dependency~~ substance misuse or ~~chemical abuse~~ substance
 328.32 use disorder to minimize or prevent further ~~chemical abuse~~ substance misuse by the person.

329.1 Diagnostic, evaluation, prevention, referral, detoxification, and aftercare services that are
 329.2 not part of a program of care licensable as a residential or nonresidential ~~chemical dependency~~
 329.3 substance use disorder treatment program are not ~~chemical dependency~~ substance use
 329.4 disorder services for purposes of this section. For pregnant and postpartum women, ~~chemical~~
 329.5 ~~dependency~~ substance use disorder services include halfway house services, aftercare
 329.6 services, psychological services, and case management.

329.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

329.8 Sec. 49. Minnesota Statutes 2016, section 254B.01, is amended by adding a subdivision
 329.9 to read:

329.10 Subd. 8. **Recovery community organization.** "Recovery community organization"
 329.11 means an independent organization led and governed by representatives of local communities
 329.12 of recovery. A recovery community organization mobilizes resources within and outside
 329.13 of the recovery community to increase the prevalence and quality of long-term recovery
 329.14 from alcohol and other drug addiction. Recovery community organizations provide
 329.15 peer-based recovery support activities such as training of recovery peers. Recovery
 329.16 community organizations provide mentorship and ongoing support to individuals dealing
 329.17 with a substance use disorder and connect them with the resources that can support each
 329.18 person's recovery. A recovery community organization also promotes a recovery-focused
 329.19 orientation in community education and outreach programming, and organize
 329.20 recovery-focused policy advocacy activities to foster healthy communities and reduce the
 329.21 stigma of substance use disorder.

329.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

329.23 Sec. 50. Minnesota Statutes 2016, section 254B.03, subdivision 2, is amended to read:

329.24 Subd. 2. **Chemical dependency fund payment.** (a) Payment from the chemical
 329.25 dependency fund is limited to payments for services other than detoxification licensed under
 329.26 Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally
 329.27 recognized tribal lands, would be required to be licensed by the commissioner as a chemical
 329.28 dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and
 329.29 services other than detoxification provided in another state that would be required to be
 329.30 licensed as a chemical dependency program if the program were in the state. Out of state
 329.31 vendors must also provide the commissioner with assurances that the program complies
 329.32 substantially with state licensing requirements and possesses all licenses and certifications
 329.33 required by the host state to provide chemical dependency treatment. ~~Except for chemical~~

330.1 ~~dependency transitional rehabilitation programs~~; Vendors receiving payments from the
330.2 chemical dependency fund must not require co-payment from a recipient of benefits for
330.3 services provided under this subdivision. The vendor is prohibited from using the client's
330.4 public benefits to offset the cost of services paid under this section. The vendor shall not
330.5 require the client to use public benefits for room or board costs. This includes but is not
330.6 limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits.
330.7 Retention of SNAP benefits is a right of a client receiving services through the consolidated
330.8 chemical dependency treatment fund or through state contracted managed care entities.
330.9 Payment from the chemical dependency fund shall be made for necessary room and board
330.10 costs provided by vendors certified according to section 254B.05, or in a community hospital
330.11 licensed by the commissioner of health according to sections 144.50 to 144.56 to a client
330.12 who is:

330.13 (1) determined to meet the criteria for placement in a residential chemical dependency
330.14 treatment program according to rules adopted under section 254A.03, subdivision 3; and

330.15 (2) concurrently receiving a chemical dependency treatment service in a program licensed
330.16 by the commissioner and reimbursed by the chemical dependency fund.

330.17 (b) A county may, from its own resources, provide chemical dependency services for
330.18 which state payments are not made. A county may elect to use the same invoice procedures
330.19 and obtain the same state payment services as are used for chemical dependency services
330.20 for which state payments are made under this section if county payments are made to the
330.21 state in advance of state payments to vendors. When a county uses the state system for
330.22 payment, the commissioner shall make monthly billings to the county using the most recent
330.23 available information to determine the anticipated services for which payments will be made
330.24 in the coming month. Adjustment of any overestimate or underestimate based on actual
330.25 expenditures shall be made by the state agency by adjusting the estimate for any succeeding
330.26 month.

330.27 (c) The commissioner shall coordinate chemical dependency services and determine
330.28 whether there is a need for any proposed expansion of chemical dependency treatment
330.29 services. The commissioner shall deny vendor certification to any provider that has not
330.30 received prior approval from the commissioner for the creation of new programs or the
330.31 expansion of existing program capacity. The commissioner shall consider the provider's
330.32 capacity to obtain clients from outside the state based on plans, agreements, and previous
330.33 utilization history, when determining the need for new treatment services.

330.34 **EFFECTIVE DATE.** This section is effective January 1, 2018.

331.1 Sec. 51. Minnesota Statutes 2016, section 254B.04, subdivision 1, is amended to read:

331.2 Subdivision 1. **Eligibility.** ~~(a)~~ Persons eligible for benefits under Code of Federal
331.3 Regulations, title 25, part 20, and persons eligible for medical assistance benefits under
331.4 sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 5, and 6, or who meet the
331.5 income standards of section 256B.056, subdivision 4, are entitled to chemical dependency
331.6 fund services. State money appropriated for this paragraph must be placed in a separate
331.7 account established for this purpose.

331.8 Persons with dependent children who are determined to be in need of chemical
331.9 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
331.10 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
331.11 local agency to access needed treatment services. Treatment services must be appropriate
331.12 for the individual or family, which may include long-term care treatment or treatment in a
331.13 facility that allows the dependent children to stay in the treatment facility. The county shall
331.14 pay for out-of-home placement costs, if applicable.

331.15 ~~(b) A person not entitled to services under paragraph (a), but with family income that~~
331.16 ~~is less than 215 percent of the federal poverty guidelines for the applicable family size, shall~~
331.17 ~~be eligible to receive chemical dependency fund services within the limit of funds~~
331.18 ~~appropriated for this group for the fiscal year. If notified by the state agency of limited~~
331.19 ~~funds, a county must give preferential treatment to persons with dependent children who~~
331.20 ~~are in need of chemical dependency treatment pursuant to an assessment under section~~
331.21 ~~626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212.~~
331.22 ~~A county may spend money from its own sources to serve persons under this paragraph.~~
331.23 ~~State money appropriated for this paragraph must be placed in a separate account established~~
331.24 ~~for this purpose.~~

331.25 ~~(c) Persons whose income is between 215 percent and 412 percent of the federal poverty~~
331.26 ~~guidelines for the applicable family size shall be eligible for chemical dependency services~~
331.27 ~~on a sliding fee basis, within the limit of funds appropriated for this group for the fiscal~~
331.28 ~~year. Persons eligible under this paragraph must contribute to the cost of services according~~
331.29 ~~to the sliding fee scale established under subdivision 3. A county may spend money from~~
331.30 ~~its own sources to provide services to persons under this paragraph. State money appropriated~~
331.31 ~~for this paragraph must be placed in a separate account established for this purpose.~~

331.32 **EFFECTIVE DATE.** This section is effective January 1, 2018.

332.1 Sec. 52. Minnesota Statutes 2016, section 254B.04, subdivision 2b, is amended to read:

332.2 Subd. 2b. **Eligibility for placement in opioid treatment programs.** ~~(a) Notwithstanding~~
332.3 ~~provisions of Minnesota Rules, part 9530.6622, subpart 5, related to a placement authority's~~
332.4 ~~requirement to authorize services or service coordination in a program that complies with~~
332.5 ~~Minnesota Rules, part 9530.6500, or Code of Federal Regulations, title 42, part 8, and after~~
332.6 ~~taking into account an individual's preference for placement in an opioid treatment program,~~
332.7 ~~a placement authority may, but is not required to, authorize services or service coordination~~
332.8 ~~or otherwise place an individual in an opioid treatment program. Prior to making a~~
332.9 ~~determination of placement for an individual, the placing authority must consult with the~~
332.10 ~~current treatment provider, if any.~~

332.11 ~~(b)~~ Prior to placement of an individual who is determined by the assessor to require
332.12 treatment for opioid addiction, the assessor must provide educational information concerning
332.13 treatment options for opioid addiction, including the use of a medication for the use of
332.14 opioid addiction. The commissioner shall develop educational materials supported by
332.15 research and updated periodically that must be used by assessors to comply with this
332.16 requirement.

332.17 **EFFECTIVE DATE.** This section is effective January 1, 2018.

332.18 Sec. 53. Minnesota Statutes 2016, section 254B.05, subdivision 1, is amended to read:

332.19 Subdivision 1. **Licensure required.** (a) Programs licensed by the commissioner are
332.20 eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors,
332.21 notwithstanding the provisions of section 245A.03. American Indian programs that provide
332.22 ~~chemical dependency primary~~ substance use disorder treatment, extended care, transitional
332.23 residence, or outpatient treatment services, and are licensed by tribal government are eligible
332.24 vendors.

332.25 (b) On July 1, 2018, or upon federal approval, whichever is later, a licensed professional
332.26 in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4,
332.27 is an eligible vendor of a comprehensive assessment and assessment summary provided
332.28 according to section 245G.05, and treatment services provided according to sections 245G.06
332.29 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2.

332.30 (c) On July 1, 2018, or upon federal approval, whichever is later, a county is an eligible
332.31 vendor for a comprehensive assessment and assessment summary when provided by an
332.32 individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 4, and
332.33 completed according to the requirements of section 245G.05. A county is an eligible vendor

333.1 of care coordination services when provided by an individual who meets the staffing
 333.2 credentials of section 245G.11, subdivisions 1 and 7, and provided according to the
 333.3 requirements of section 245G.07, subdivision 1, clause (7).

333.4 (d) On July 1, 2018, or upon federal approval, whichever is later, a recovery community
 333.5 organization that meets certification requirements identified by the commissioner is an
 333.6 eligible vendor of peer support services.

333.7 (e) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to
 333.8 9530.6590, are not eligible vendors. Programs that are not licensed as a chemical dependency
 333.9 residential or nonresidential substance use disorder treatment or withdrawal management
 333.10 program by the commissioner or by tribal government or do not meet the requirements of
 333.11 subdivisions 1a and 1b are not eligible vendors.

333.12 **EFFECTIVE DATE.** This section is effective January 1, 2018.

333.13 Sec. 54. Minnesota Statutes 2016, section 254B.05, subdivision 1a, is amended to read:

333.14 Subd. 1a. **Room and board provider requirements.** (a) Effective January 1, 2000,
 333.15 vendors of room and board are eligible for chemical dependency fund payment if the vendor:

333.16 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
 333.17 while residing in the facility and provide consequences for infractions of those rules;

333.18 (2) is determined to meet applicable health and safety requirements;

333.19 (3) is not a jail or prison;

333.20 (4) is not concurrently receiving funds under chapter 256I for the recipient;

333.21 (5) admits individuals who are 18 years of age or older;

333.22 (6) is registered as a board and lodging or lodging establishment according to section
 333.23 157.17;

333.24 (7) has awake staff on site 24 hours per day;

333.25 (8) has staff who are at least 18 years of age and meet the requirements of ~~Minnesota~~
 333.26 ~~Rules, part 9530.6450, subpart 1, item A~~ section 245G.11, subdivision 1, paragraph (a);

333.27 (9) has emergency behavioral procedures that meet the requirements of ~~Minnesota Rules,~~
 333.28 ~~part 9530.6475~~ section 245G.16;

333.29 (10) meets the requirements of ~~Minnesota Rules, part 9530.6435, subparts 3 and 4, items~~
 333.30 ~~A and B~~ section 245G.08, subdivision 5, if administering medications to clients;

334.1 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
 334.2 fraternization and the mandatory reporting requirements of section 626.557;

334.3 (12) documents coordination with the treatment provider to ensure compliance with
 334.4 section 254B.03, subdivision 2;

334.5 (13) protects client funds and ensures freedom from exploitation by meeting the
 334.6 provisions of section 245A.04, subdivision 13;

334.7 (14) has a grievance procedure that meets the requirements of ~~Minnesota Rules, part~~
 334.8 ~~9530.6470, subpart 2~~ section 245G.15, subdivision 2; and

334.9 (15) has sleeping and bathroom facilities for men and women separated by a door that
 334.10 is locked, has an alarm, or is supervised by awake staff.

334.11 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from
 334.12 paragraph (a), clauses (5) to (15).

334.13 **EFFECTIVE DATE.** This section is effective January 1, 2018.

334.14 Sec. 55. Minnesota Statutes 2016, section 254B.05, subdivision 5, is amended to read:

334.15 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for ~~chemical~~
 334.16 ~~dependency~~ substance use disorder services and service enhancements funded under this
 334.17 chapter.

334.18 (b) Eligible ~~chemical dependency~~ substance use disorder treatment services include:

334.19 (1) outpatient treatment services that are licensed according to ~~Minnesota Rules, parts~~
 334.20 ~~9530.6405 to 9530.6480~~ sections 245G.01 to 245G.17, or applicable tribal license;

334.21 (2) on July 1, 2018, or upon federal approval, whichever is later, comprehensive
 334.22 assessments provided according to sections 245.4863, paragraph (a), and 245G.05, and
 334.23 Minnesota Rules, part 9530.6422;

334.24 (3) on July 1, 2018, or upon federal approval, whichever is later, care coordination
 334.25 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (6);

334.26 (4) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support
 334.27 services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

334.28 (5) on July 1, 2018, or upon federal approval, whichever is later, withdrawal management
 334.29 services provided according to chapter 245F;

335.1 ~~(2)~~ (6) medication-assisted therapy services that are licensed according to ~~Minnesota~~
 335.2 ~~Rules, parts 9530.6405 to 9530.6480 and 9530.6500~~ section 245G.07, subdivision 1, or
 335.3 applicable tribal license;

335.4 ~~(3)~~ (7) medication-assisted therapy plus enhanced treatment services that meet the
 335.5 requirements of clause ~~(2)~~ (6) and provide nine hours of clinical services each week;

335.6 ~~(4)~~ (8) high, medium, and low intensity residential treatment services that are licensed
 335.7 according to ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505~~, sections
 335.8 245G.01 to 245G.17 and 245G.22 or applicable tribal license which provide, respectively,
 335.9 30, 15, and five hours of clinical services each week;

335.10 ~~(5)~~ (9) hospital-based treatment services that are licensed according to ~~Minnesota Rules,~~
 335.11 ~~parts 9530.6405 to 9530.6480~~, sections 245G.01 to 245G.17 or applicable tribal license and
 335.12 licensed as a hospital under sections 144.50 to 144.56;

335.13 ~~(6)~~ (10) adolescent treatment programs that are licensed as outpatient treatment programs
 335.14 according to ~~Minnesota Rules, parts 9530.6405 to 9530.6485~~, sections 245G.01 to 245G.18
 335.15 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to
 335.16 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

335.17 ~~(7)~~ (11) high-intensity residential treatment services that are licensed according to
 335.18 ~~Minnesota Rules, parts 9530.6405 to 9530.6480 and 9530.6505~~, sections 245G.01 to 245G.17
 335.19 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each
 335.20 week provided by a state-operated vendor or to clients who have been civilly committed to
 335.21 the commissioner, present the most complex and difficult care needs, and are a potential
 335.22 threat to the community; and

335.23 ~~(8)~~ (12) room and board facilities that meet the requirements of subdivision 1a.

335.24 (c) The commissioner shall establish higher rates for programs that meet the requirements
 335.25 of paragraph (b) and one of the following additional requirements:

335.26 (1) programs that serve parents with their children if the program:

335.27 (i) provides on-site child care during the hours of treatment activity that:

335.28 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
 335.29 9503; or

335.30 (B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph
 335.31 (a), clause (6), and meets the requirements under ~~Minnesota Rules, part 9530.6490, subpart~~
 335.32 4 section 245G.19, subdivision 4; or

336.1 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
336.2 licensed under chapter 245A as:

336.3 (A) a child care center under Minnesota Rules, chapter 9503; or

336.4 (B) a family child care home under Minnesota Rules, chapter 9502;

336.5 (2) culturally specific programs as defined in section 254B.01, subdivision 4a, or
336.6 programs or subprograms serving special populations, if the program or subprogram meets
336.7 the following requirements:

336.8 (i) is designed to address the unique needs of individuals who share a common language,
336.9 racial, ethnic, or social background;

336.10 (ii) is governed with significant input from individuals of that specific background; and

336.11 (iii) employs individuals to provide individual or group therapy, at least 50 percent of
336.12 whom are of that specific background, except when the common social background of the
336.13 individuals served is a traumatic brain injury or cognitive disability and the program employs
336.14 treatment staff who have the necessary professional training, as approved by the
336.15 commissioner, to serve clients with the specific disabilities that the program is designed to
336.16 serve;

336.17 (3) programs that offer medical services delivered by appropriately credentialed health
336.18 care staff in an amount equal to two hours per client per week if the medical needs of the
336.19 client and the nature and provision of any medical services provided are documented in the
336.20 client file; and

336.21 (4) programs that offer services to individuals with co-occurring mental health and
336.22 chemical dependency problems if:

336.23 (i) the program meets the co-occurring requirements in ~~Minnesota Rules, part 9530.6495~~
336.24 section 245G.20;

336.25 (ii) 25 percent of the counseling staff are licensed mental health professionals, as defined
336.26 in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates
336.27 under the supervision of a licensed alcohol and drug counselor supervisor and licensed
336.28 mental health professional, except that no more than 50 percent of the mental health staff
336.29 may be students or licensing candidates with time documented to be directly related to
336.30 provisions of co-occurring services;

336.31 (iii) clients scoring positive on a standardized mental health screen receive a mental
336.32 health diagnostic assessment within ten days of admission;

337.1 (iv) the program has standards for multidisciplinary case review that include a monthly
 337.2 review for each client that, at a minimum, includes a licensed mental health professional
 337.3 and licensed alcohol and drug counselor, and their involvement in the review is documented;

337.4 (v) family education is offered that addresses mental health and substance abuse disorders
 337.5 and the interaction between the two; and

337.6 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
 337.7 training annually.

337.8 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
 337.9 that provides arrangements for off-site child care must maintain current documentation at
 337.10 the chemical dependency facility of the child care provider's current licensure to provide
 337.11 child care services. Programs that provide child care according to paragraph (c), clause (1),
 337.12 must be deemed in compliance with the licensing requirements in ~~Minnesota Rules, part~~
 337.13 ~~9530.6490~~ section 245G.19.

337.14 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,
 337.15 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements
 337.16 in paragraph (c), clause (4), items (i) to (iv).

337.17 (f) Subject to federal approval, chemical dependency services that are otherwise covered
 337.18 as direct face-to-face services may be provided via two-way interactive video. The use of
 337.19 two-way interactive video must be medically appropriate to the condition and needs of the
 337.20 person being served. Reimbursement shall be at the same rates and under the same conditions
 337.21 that would otherwise apply to direct face-to-face services. The interactive video equipment
 337.22 and connection must comply with Medicare standards in effect at the time the service is
 337.23 provided.

337.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

337.25 Sec. 56. Minnesota Statutes 2016, section 254B.051, is amended to read:

337.26 **254B.051 SUBSTANCE ABUSE USE DISORDER TREATMENT**
 337.27 **EFFECTIVENESS.**

337.28 In addition to the substance ~~abuse~~ use disorder treatment program performance outcome
 337.29 measures that the commissioner of human services collects annually from treatment providers,
 337.30 the commissioner shall request additional data from programs that receive appropriations
 337.31 from the consolidated chemical dependency treatment fund. This data shall include number
 337.32 of client readmissions six months after release from inpatient treatment, and the cost of

338.1 treatment per person for each program receiving consolidated chemical dependency treatment
338.2 funds. The commissioner may post this data on the department Web site.

338.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

338.4 Sec. 57. Minnesota Statutes 2016, section 254B.07, is amended to read:

338.5 **254B.07 THIRD-PARTY LIABILITY.**

338.6 The state agency provision and payment of, or liability for, ~~chemical dependency~~
338.7 substance use disorder medical care is the same as in section 256B.042.

338.8 **EFFECTIVE DATE.** This section is effective January 1, 2018.

338.9 Sec. 58. Minnesota Statutes 2016, section 254B.08, is amended to read:

338.10 **254B.08 FEDERAL WAIVERS.**

338.11 The commissioner shall apply for any federal waivers necessary to secure, to the extent
338.12 allowed by law, federal financial participation for the provision of services to persons who
338.13 need ~~chemical dependency~~ substance use disorder services. The commissioner may seek
338.14 amendments to the waivers or apply for additional waivers to contain costs. The
338.15 commissioner shall ensure that payment for the cost of providing ~~chemical dependency~~
338.16 substance use disorder services under the federal waiver plan does not exceed the cost of
338.17 ~~chemical dependency~~ substance use disorder services that would have been provided without
338.18 the waived services.

338.19 **EFFECTIVE DATE.** This section is effective January 1, 2018.

338.20 Sec. 59. Minnesota Statutes 2016, section 254B.09, is amended to read:

338.21 **254B.09 INDIAN RESERVATION ALLOCATION OF CHEMICAL**
338.22 **DEPENDENCY FUND.**

338.23 Subdivision 1. **Vendor payments.** The commissioner shall pay eligible vendors for
338.24 ~~chemical dependency~~ substance use disorder services to American Indians on the same
338.25 basis as other payments, except that no local match is required when an invoice is submitted
338.26 by the governing authority of a federally recognized American Indian tribal body or a county
338.27 if the tribal governing body has not entered into an agreement under subdivision 2 on behalf
338.28 of a current resident of the reservation under this section.

338.29 Subd. 2. **American Indian agreements.** The commissioner may enter into agreements
338.30 with federally recognized tribal units to pay for ~~chemical dependency~~ substance use disorder

339.1 treatment services provided under Laws 1986, chapter 394, sections 8 to 20. The agreements
339.2 must clarify how the governing body of the tribal unit fulfills local agency responsibilities
339.3 regarding:

339.4 (1) the form and manner of invoicing; and

339.5 (2) provide that only invoices for eligible vendors according to section 254B.05 will be
339.6 included in invoices sent to the commissioner for payment, to the extent that money allocated
339.7 under subdivisions 4 and 5 is used.

339.8 Subd. 6. **American Indian tribal placements.** After entering into an agreement under
339.9 subdivision 2, the governing authority of each reservation may submit invoices to the state
339.10 for the cost of providing ~~chemical dependency~~ substance use disorder services to residents
339.11 of the reservation according to the placement rules governing county placements, except
339.12 that local match requirements are waived. The governing body may designate an agency to
339.13 act on its behalf to provide placement services and manage invoices by written notice to
339.14 the commissioner and evidence of agreement by the agency designated.

339.15 Subd. 8. **Payments to improve services to American Indians.** The commissioner may
339.16 set rates for ~~chemical dependency~~ substance use disorder services to American Indians
339.17 according to the American Indian Health Improvement Act, Public Law 94-437, for eligible
339.18 vendors. These rates shall supersede rates set in county purchase of service agreements
339.19 when payments are made on behalf of clients eligible according to Public Law 94-437.

339.20 **EFFECTIVE DATE.** This section is effective January 1, 2018.

339.21 Sec. 60. Minnesota Statutes 2016, section 254B.12, subdivision 2, is amended to read:

339.22 Subd. 2. **Payment methodology for highly specialized vendors.** Notwithstanding
339.23 subdivision 1, the commissioner shall seek federal authority to develop separate payment
339.24 methodologies for ~~chemical dependency~~ substance use disorder treatment services provided
339.25 under the consolidated chemical dependency treatment fund: (1) by a state-operated vendor;
339.26 or (2) for persons who have been civilly committed to the commissioner, present the most
339.27 complex and difficult care needs, and are a potential threat to the community. A payment
339.28 methodology under this subdivision is effective for services provided on or after October
339.29 1, 2015, or on or after the receipt of federal approval, whichever is later.

339.30 **EFFECTIVE DATE.** This section is effective January 1, 2018.

340.1 Sec. 61. Minnesota Statutes 2016, section 254B.12, is amended by adding a subdivision
340.2 to read:

340.3 Subd. 3. **Chemical dependency provider rate increase.** For the chemical dependency
340.4 services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2017,
340.5 payment rates shall be increased by three percent over the rates in effect on January 1, 2017,
340.6 for vendors who meet the requirements of section 254B.05.

340.7 Sec. 62. Minnesota Statutes 2016, section 254B.13, subdivision 2a, is amended to read:

340.8 Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation
340.9 in a navigator pilot program, an individual must:

340.10 (1) be a resident of a county with an approved navigator program;

340.11 (2) be eligible for consolidated chemical dependency treatment fund services;

340.12 (3) be a voluntary participant in the navigator program;

340.13 (4) satisfy one of the following items:

340.14 (i) have at least one severity rating of three or above in dimension four, five, or six in a
340.15 comprehensive assessment under ~~Minnesota Rules, part 9530.6422~~ section 245G.05,
340.16 paragraph (c), clauses (4) to (6); or

340.17 (ii) have at least one severity rating of two or above in dimension four, five, or six in a
340.18 comprehensive assessment under ~~Minnesota Rules, part 9530.6422~~, section 245G.05,
340.19 paragraph (c), clauses (4) to (6), and be currently participating in a Rule 31 treatment program
340.20 under ~~Minnesota Rules, parts 9530.6405 to 9530.6505~~, chapter 245G or be within 60 days
340.21 following discharge after participation in a Rule 31 treatment program; and

340.22 (5) have had at least two treatment episodes in the past two years, not limited to episodes
340.23 reimbursed by the consolidated chemical dependency treatment funds. An admission to an
340.24 emergency room, a detoxification program, or a hospital may be substituted for one treatment
340.25 episode if it resulted from the individual's substance use disorder.

340.26 (b) New eligibility criteria may be added as mutually agreed upon by the commissioner
340.27 and participating navigator programs.

340.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

341.1 Sec. 63. Minnesota Statutes 2016, section 256B.0625, subdivision 45a, is amended to
341.2 read:

341.3 Subd. 45a. **Psychiatric residential treatment facility services for persons under 21**
341.4 **years of age.** (a) Medical assistance covers psychiatric residential treatment facility services,
341.5 according to section 256B.0941, for persons ~~under~~ younger than 21 years of age. Individuals
341.6 who reach age 21 at the time they are receiving services are eligible to continue receiving
341.7 services until they no longer require services or until they reach age 22, whichever occurs
341.8 first.

341.9 (b) For purposes of this subdivision, "psychiatric residential treatment facility" means
341.10 a facility other than a hospital that provides psychiatric services, as described in Code of
341.11 Federal Regulations, title 42, sections 441.151 to 441.182, to individuals under age 21 in
341.12 an inpatient setting.

341.13 ~~(c) The commissioner shall develop admissions and discharge procedures and establish~~
341.14 ~~rates consistent with guidelines from the federal Centers for Medicare and Medicaid Services.~~

341.15 ~~(d)~~ The commissioner shall enroll up to 150 certified psychiatric residential treatment
341.16 facility services beds at up to six sites. The commissioner shall select psychiatric residential
341.17 treatment facility services providers through a request for proposals process. Providers of
341.18 state-operated services may respond to the request for proposals.

341.19 **EFFECTIVE DATE.** This section is effective the day following final enactment.

341.20 Sec. 64. **[256B.0941] PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY**
341.21 **FOR PERSONS UNDER 21 YEARS OF AGE.**

341.22 Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment
341.23 services in a psychiatric residential treatment facility must meet all of the following criteria:

341.24 (1) before admission, services are determined to be medically necessary by the state's
341.25 medical review agent according to Code of Federal Regulations, title 42, section 441.152;

341.26 (2) is younger than 21 years of age at the time of admission. Services may continue until
341.27 the individual meets criteria for discharge or reaches 22 years of age, whichever occurs
341.28 first;

341.29 (3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic
341.30 and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression,
341.31 or a finding that the individual is a risk to self or others;

342.1 (4) has functional impairment and a history of difficulty in functioning safely and
342.2 successfully in the community, school, home, or job; an inability to adequately care for
342.3 one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill
342.4 the individual's needs;

342.5 (5) requires psychiatric residential treatment under the direction of a physician to improve
342.6 the individual's condition or prevent further regression so that services will no longer be
342.7 needed;

342.8 (6) utilized and exhausted other community-based mental health services, or clinical
342.9 evidence indicates that such services cannot provide the level of care needed; and

342.10 (7) was referred for treatment in a psychiatric residential treatment facility by a qualified
342.11 mental health professional licensed as defined in section 245.4871, subdivision 27, clauses
342.12 (1) to (6).

342.13 (b) A mental health professional making a referral shall submit documentation to the
342.14 state's medical review agent containing all information necessary to determine medical
342.15 necessity, including a standard diagnostic assessment completed within 180 days of the
342.16 individual's admission. Documentation shall include evidence of family participation in the
342.17 individual's treatment planning and signed consent for services.

342.18 Subd. 2. Services. Psychiatric residential treatment facility service providers must offer
342.19 and have the capacity to provide the following services:

342.20 (1) development of the individual plan of care, review of the individual plan of care
342.21 every 30 days, and discharge planning by required members of the treatment team according
342.22 to Code of Federal Regulations, title 42, sections 441.155 to 441.156;

342.23 (2) any services provided by a psychiatrist or physician for development of an individual
342.24 plan of care, conducting a review of the individual plan of care every 30 days, and discharge
342.25 planning by required members of the treatment team according to Code of Federal
342.26 Regulations, title 42, sections 441.155 to 441.156;

342.27 (3) active treatment seven days per week that may include individual, family, or group
342.28 therapy as determined by the individual care plan;

342.29 (4) individual therapy, provided a minimum of twice per week;

342.30 (5) family engagement activities, provided a minimum of once per week;

343.1 (6) consultation with other professionals, including case managers, primary care
343.2 professionals, community-based mental health providers, school staff, or other support
343.3 planners;

343.4 (7) coordination of educational services between local and resident school districts and
343.5 the facility;

343.6 (8) 24-hour nursing; and

343.7 (9) direct care and supervision, supportive services for daily living and safety, and
343.8 positive behavior management.

343.9 Subd. 3. **Per diem rate.** (a) The commissioner shall establish a statewide per diem rate
343.10 for psychiatric residential treatment facility services for individuals 21 years of age or
343.11 younger. The rate for a provider must not exceed the rate charged by that provider for the
343.12 same service to other payers. Payment must not be made to more than one entity for each
343.13 individual for services provided under this section on a given day. The commissioner shall
343.14 set rates prospectively for the annual rate period. The commissioner shall require providers
343.15 to submit annual cost reports on a uniform cost reporting form and shall use submitted cost
343.16 reports to inform the rate-setting process. The cost reporting shall be done according to
343.17 federal requirements for Medicare cost reports.

343.18 (b) The following are included in the rate:

343.19 (1) costs necessary for licensure and accreditation, meeting all staffing standards for
343.20 participation, meeting all service standards for participation, meeting all requirements for
343.21 active treatment, maintaining medical records, conducting utilization review, meeting
343.22 inspection of care, and discharge planning. The direct services costs must be determined
343.23 using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff
343.24 and service-related transportation; and

343.25 (2) payment for room and board provided by facilities meeting all accreditation and
343.26 licensing requirements for participation.

343.27 (c) A facility may submit a claim for payment outside of the per diem for professional
343.28 services arranged by and provided at the facility by an appropriately licensed professional
343.29 who is enrolled as a provider with Minnesota health care programs. Arranged services must
343.30 be billed by the facility on a separate claim, and the facility shall be responsible for payment
343.31 to the provider. These services must be included in the individual plan of care and are subject
343.32 to prior authorization by the state's medical review agent.

344.1 (d) Medicaid shall reimburse for concurrent services as approved by the commissioner
344.2 to support continuity of care and successful discharge from the facility. "Concurrent services"
344.3 means services provided by another entity or provider while the individual is admitted to a
344.4 psychiatric residential treatment facility. Payment for concurrent services may be limited
344.5 and these services are subject to prior authorization by the state's medical review agent.
344.6 Concurrent services may include targeted case management, assertive community treatment,
344.7 clinical care consultation, team consultation, and treatment planning.

344.8 (e) Payment rates under this subdivision shall not include the costs of providing the
344.9 following services:

344.10 (1) educational services;

344.11 (2) acute medical care or specialty services for other medical conditions;

344.12 (3) dental services; and

344.13 (4) pharmacy drug costs.

344.14 (f) For purposes of this section, "actual cost" means costs that are allowable, allocable,
344.15 reasonable, and consistent with federal reimbursement requirements in Code of Federal
344.16 Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of
344.17 Management and Budget Circular Number A-122, relating to nonprofit entities.

344.18 Subd. 4. **Leave days.** (a) Medical assistance covers therapeutic and hospital leave days,
344.19 provided the recipient was not discharged from the psychiatric residential treatment facility
344.20 and is expected to return to the psychiatric residential treatment facility. A reserved bed
344.21 must be held for a recipient on hospital leave or therapeutic leave.

344.22 (b) A therapeutic leave day to home shall be used to prepare for discharge and
344.23 reintegration and shall be included in the individual plan of care. The state shall reimburse
344.24 75 percent of the per diem rate for a reserve bed day while the recipient is on therapeutic
344.25 leave. A therapeutic leave visit may not exceed three days without prior authorization.

344.26 (c) A hospital leave day shall be a day for which a recipient has been admitted to a
344.27 hospital for medical or acute psychiatric care and is temporarily absent from the psychiatric
344.28 residential treatment facility. The state shall reimburse 50 percent of the per diem rate for
344.29 a reserve bed day while the recipient is receiving medical or psychiatric care in a hospital.

344.30 **EFFECTIVE DATE.** This section is effective the day following final enactment.

345.1 Sec. 65. Minnesota Statutes 2016, section 256B.0943, subdivision 13, is amended to read:

345.2 Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15
345.3 hours of children's therapeutic services and supports provided within a six-month period to
345.4 a child with severe emotional disturbance who is residing in a hospital; ~~a group home as~~
345.5 ~~defined in Minnesota Rules, parts 2960.0130 to 2960.0220;~~ a residential treatment facility
345.6 licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential
345.7 treatment facility under section 256B.0625, subdivision 45a; a regional treatment center;
345.8 or other institutional group setting or who is participating in a program of partial
345.9 hospitalization are eligible for medical assistance payment if part of the discharge plan.

345.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

345.11 Sec. 66. Minnesota Statutes 2016, section 256B.0945, subdivision 2, is amended to read:

345.12 Subd. 2. **Covered services.** All services must be included in a child's individualized
345.13 treatment or multiagency plan of care as defined in chapter 245.

345.14 For facilities that are not institutions for mental diseases according to federal statute and
345.15 regulation, medical assistance covers mental health-related services that are required to be
345.16 provided by a residential facility under section 245.4882 and administrative rules promulgated
345.17 thereunder, except for room and board. For residential facilities determined by the federal
345.18 Centers for Medicare and Medicaid Services to be an institution for mental diseases, medical
345.19 assistance covers medically necessary mental health services provided by the facility
345.20 according to section 256B.055, subdivision 13, except for room and board.

345.21 Sec. 67. Minnesota Statutes 2016, section 256B.0945, subdivision 4, is amended to read:

345.22 Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments
345.23 to counties for residential services provided under this section by a residential facility shall:

345.24 (1) for services provided by a residential facility that is not an institution for mental
345.25 diseases, only be made of federal earnings for services provided ~~under this section~~, and the
345.26 nonfederal share of costs for services provided under this section shall be paid by the county
345.27 from sources other than federal funds or funds used to match other federal funds. Payment
345.28 to counties for services provided according to this section shall be a proportion of the per
345.29 day contract rate that relates to rehabilitative mental health services and shall not include
345.30 payment for costs or services that are billed to the IV-E program as room and board; and

345.31 (2) for services provided by a residential facility that is determined to be an institution
345.32 for mental diseases, be equivalent to the federal share of the payment that would have been

346.1 made if the residential facility were not an institution for mental diseases. The portion of
 346.2 the payment representing what would be the nonfederal shares shall be paid by the county.
 346.3 Payment to counties for services provided according to this section shall be a proportion of
 346.4 the per day contract rate that relates to rehabilitative mental health services and shall not
 346.5 include payment for costs or services that are billed to the IV-E program as room and board.

346.6 (b) Per diem rates paid to providers under this section by prepaid plans shall be the
 346.7 proportion of the per-day contract rate that relates to rehabilitative mental health services
 346.8 and shall not include payment for group foster care costs or services that are billed to the
 346.9 county of financial responsibility. Services provided in facilities located in bordering states
 346.10 are eligible for reimbursement on a fee-for-service basis only as described in paragraph (a)
 346.11 and are not covered under prepaid health plans.

346.12 (c) Payment for mental health rehabilitative services provided under this section by or
 346.13 under contract with an American Indian tribe or tribal organization or by agencies operated
 346.14 by or under contract with an American Indian tribe or tribal organization must be made
 346.15 according to section 256B.0625, subdivision 34, or other relevant federally approved
 346.16 rate-setting methodology.

346.17 (d) The commissioner shall set aside a portion not to exceed five percent of the federal
 346.18 funds earned for county expenditures under this section to cover the state costs of
 346.19 administering this section. Any unexpended funds from the set-aside shall be distributed to
 346.20 the counties in proportion to their earnings under this section.

346.21 Sec. 68. Minnesota Statutes 2016, section 256B.763, is amended to read:

346.22 **256B.763 CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

346.23 (a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment
 346.24 rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

346.25 (1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

346.26 (2) community mental health centers under section 256B.0625, subdivision 5; and

346.27 (3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750
 346.28 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential
 346.29 community providers under section 62Q.19.

346.30 (b) This increase applies to group skills training when provided as a component of
 346.31 children's therapeutic services and support, psychotherapy, medication management,

347.1 evaluation and management, diagnostic assessment, explanation of findings, psychological
347.2 testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

347.3 (c) This increase does not apply to rates that are governed by section 256B.0625,
347.4 subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated
347.5 with the county, rates that are established by the federal government, or rates that increased
347.6 between January 1, 2004, and January 1, 2005.

347.7 (d) The commissioner shall adjust rates paid to prepaid health plans under contract with
347.8 the commissioner to reflect the rate increases provided in paragraphs (a), (e), and (f). The
347.9 prepaid health plan must pass this rate increase to the providers identified in paragraphs (a),
347.10 (e), (f), and (g).

347.11 (e) Payment rates shall be increased by 23.7 percent over the rates in effect on December
347.12 31, 2007, for:

347.13 (1) medication education services provided on or after January 1, 2008, by adult
347.14 rehabilitative mental health services providers certified under section 256B.0623; and

347.15 (2) mental health behavioral aide services provided on or after January 1, 2008, by
347.16 children's therapeutic services and support providers certified under section 256B.0943.

347.17 (f) For services defined in paragraph (b) and rendered on or after January 1, 2008, by
347.18 children's therapeutic services and support providers certified under section 256B.0943 and
347.19 not already included in paragraph (a), payment rates shall be increased by 23.7 percent over
347.20 the rates in effect on December 31, 2007.

347.21 (g) Payment rates shall be increased by 2.3 percent over the rates in effect on December
347.22 31, 2007, for individual and family skills training provided on or after January 1, 2008, by
347.23 children's therapeutic services and support providers certified under section 256B.0943.

347.24 (h) For services described in paragraphs (b), (e), and (g) and rendered on or after July
347.25 1, 2017, payment rates for mental health clinics and centers certified under Minnesota Rules,
347.26 parts 9520.0750 to 9520.0870, that are not designated as essential community providers
347.27 under section 62Q.19 shall be equal to payment rates for mental health clinics and centers
347.28 certified under Minnesota Rules, parts 9520.0750 to 9520.0870, that are designated as
347.29 essential community providers under section 62Q.19. In order to receive increased payment
347.30 rates under this paragraph, a provider must demonstrate a commitment to serve low-income
347.31 and underserved populations by:

347.32 (1) charging for services on a sliding-fee schedule based on current poverty income
347.33 guidelines; and

348.1 (2) not restricting access or services because of a client's financial limitation.

348.2 **Sec. 69. CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.**

348.3 The commissioner of human services shall conduct a comprehensive analysis of
348.4 Minnesota's continuum of intensive mental health services and shall develop
348.5 recommendations for a sustainable and community-driven continuum of care for children
348.6 with serious mental health needs, including children currently being served in residential
348.7 treatment. The commissioner's analysis shall include, but not be limited to:

348.8 (1) data related to access, utilization, efficacy, and outcomes for Minnesota's current
348.9 system of residential mental health treatment for a child with a severe emotional disturbance;

348.10 (2) potential expansion of the state's psychiatric residential treatment facility (PRTF)
348.11 capacity, including increasing the number of PRTF beds and conversion of existing children's
348.12 mental health residential treatment programs into PRTFs;

348.13 (3) the capacity need for PRTF and other group settings within the state if adequate
348.14 community-based alternatives are accessible, equitable, and effective statewide;

348.15 (4) recommendations for expanding alternative community-based service models to
348.16 meet the needs of a child with a serious mental health disorder who would otherwise require
348.17 residential treatment and potential service models that could be utilized, including data
348.18 related to access, utilization, efficacy, and outcomes;

348.19 (5) models of care used in other states; and

348.20 (6) analysis and specific recommendations for the design and implementation of new
348.21 service models, including analysis to inform rate setting as necessary.

348.22 The analysis shall be supported and informed by extensive stakeholder engagement.
348.23 Stakeholders include individuals who receive services, family members of individuals who
348.24 receive services, providers, counties, health plans, advocates, and others. Stakeholder
348.25 engagement shall include interviews with key stakeholders, intentional outreach to individuals
348.26 who receive services and the individual's family members, and regional listening sessions.

348.27 The commissioner shall provide a report with specific recommendations and timelines
348.28 for implementation to the legislative committees with jurisdiction over children's mental
348.29 health policy and finance by November 15, 2018.

349.1 **Sec. 70. RESIDENTIAL TREATMENT AND PAYMENT RATE REFORM.**

349.2 The commissioner shall contract with an outside expert to identify recommendations
349.3 for the development of a substance use disorder residential treatment program model and
349.4 payment structure that is not subject to the federal institutions for mental diseases exclusion
349.5 and that is financially sustainable for providers, while incentivizing best practices and
349.6 improved treatment outcomes. The analysis must include recommendations and a timeline
349.7 for supporting providers to transition to the new models of care delivery. No later than
349.8 December 15, 2018, the commissioner shall deliver a report with recommendations to the
349.9 chairs and ranking minority members of the legislative committees with jurisdiction over
349.10 health and human services policy and finance.

349.11 **Sec. 71. REVISOR'S INSTRUCTION.**

349.12 In Minnesota Statutes and Minnesota Rules, the revisor of statutes, in consultation with
349.13 the with the Department of Human Services, shall make necessary cross-reference changes
349.14 that are needed as a result of the enactment of sections 7 to 28 and 70. The revisor shall
349.15 make any necessary technical and grammatical changes to preserve the meaning of the text.

349.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

349.17 **Sec. 72. REPEALER.**

349.18 (a) Minnesota Statutes 2016, sections 245A.1915; 245A.192; and 254A.02, subdivision
349.19 4, are repealed.

349.20 (b) Minnesota Rules, parts 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11,
349.21 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, and 21; 9530.6410; 9530.6415;
349.22 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445;
349.23 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480;
349.24 9530.6485; 9530.6490; 9530.6495; 9530.6500; and 9530.6505, are repealed.

349.25 (c) Minnesota Statutes 2016, section 256B.7631, is repealed.

349.26 **EFFECTIVE DATE.** Paragraphs (a) and (b) are effective January 1, 2018. Paragraph
349.27 (c) is effective the day following final enactment.

349.28 **ARTICLE 9**

349.29 **OPERATIONS**

349.30 **Section 1.** Minnesota Statutes 2016, section 245A.02, subdivision 2b, is amended to read:

350.1 Subd. 2b. **Annual or annually.** With the exception of subdivision 2c, "annual" or
350.2 "annually" means prior to or within the same month of the subsequent calendar year.

350.3 Sec. 2. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to
350.4 read:

350.5 Subd. 2c. **Annual or annually; family child care training requirements.** For the
350.6 purposes of section 245A.50, subdivisions 1 to 9, "annual" or "annually" means the 12-month
350.7 period beginning on the license effective date or the annual anniversary of the effective date
350.8 and ending on the day prior to the annual anniversary of the license effective date.

350.9 Sec. 3. Minnesota Statutes 2016, section 245A.04, subdivision 4, is amended to read:

350.10 Subd. 4. **Inspections; waiver.** (a) Before issuing an initial license, the commissioner
350.11 shall conduct an inspection of the program. The inspection must include but is not limited
350.12 to:

350.13 (1) an inspection of the physical plant;

350.14 (2) an inspection of records and documents;

350.15 (3) an evaluation of the program by consumers of the program; and

350.16 (4) observation of the program in operation.

350.17 For the purposes of this subdivision, "consumer" means a person who receives the
350.18 services of a licensed program, the person's legal guardian, or the parent or individual having
350.19 legal custody of a child who receives the services of a licensed program.

350.20 (b) The evaluation required in paragraph (a), clause (3)₂ or the observation in paragraph
350.21 (a), clause (4)₂ is not required prior to issuing an initial license under subdivision 7. If the
350.22 commissioner issues an initial license under subdivision 7, these requirements must be
350.23 completed within one year after the issuance of an initial license.

350.24 (c) Before completing a licensing inspection in a family child care program or child care
350.25 center, the licensing agency must offer the license holder an exit interview to discuss
350.26 violations of law or rule observed during the inspection and offer technical assistance on
350.27 how to comply with applicable laws and rules. Nothing in this paragraph limits the ability
350.28 of the commissioner to issue a correction order or negative action for violations of law or
350.29 rule not discussed in an exit interview or in the event that a license holder chooses not to
350.30 participate in an exit interview.

350.31 **EFFECTIVE DATE.** This section is effective October 1, 2017.

351.1 Sec. 4. Minnesota Statutes 2016, section 245A.06, subdivision 2, is amended to read:

351.2 Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder
351.3 believes that the contents of the commissioner's correction order are in error, the applicant
351.4 or license holder may ask the Department of Human Services to reconsider the parts of the
351.5 correction order that are alleged to be in error. The request for reconsideration must be made
351.6 in writing and must be postmarked and sent to the commissioner within 20 calendar days
351.7 after receipt of the correction order by the applicant or license holder, and:

351.8 (1) specify the parts of the correction order that are alleged to be in error;

351.9 (2) explain why they are in error; and

351.10 (3) include documentation to support the allegation of error.

351.11 A request for reconsideration does not stay any provisions or requirements of the
351.12 correction order. The commissioner's disposition of a request for reconsideration is final
351.13 and not subject to appeal under chapter 14.

351.14 (b) This paragraph applies only to licensed family child care providers. A licensed family
351.15 child care provider who requests reconsideration of a correction order under paragraph (a)
351.16 may also request, on a form and in the manner prescribed by the commissioner, that the
351.17 commissioner expedite the review if:

351.18 (1) the provider is challenging a violation and provides a description of how complying
351.19 with the corrective action for that violation would require the substantial expenditure of
351.20 funds or a significant change to their program; and

351.21 (2) describes what actions the provider will take in lieu of the corrective action ordered
351.22 to ensure the health and safety of children in care pending the commissioner's review of the
351.23 correction order.

351.24 Sec. 5. Minnesota Statutes 2016, section 245A.06, subdivision 8, is amended to read:

351.25 Subd. 8. **Requirement to post correction order.** (a) For licensed family child care
351.26 providers and child care centers, upon receipt of any correction order or order of conditional
351.27 license issued by the commissioner under this section, and notwithstanding a pending request
351.28 for reconsideration of the correction order or order of conditional license by the license
351.29 holder, the license holder shall post the correction order or order of conditional license in
351.30 a place that is conspicuous to the people receiving services and all visitors to the facility
351.31 for two years. When the correction order or order of conditional license is accompanied by
351.32 a maltreatment investigation memorandum prepared under section 626.556 or 626.557, the

352.1 investigation memoranda must be posted with the correction order or order of conditional
352.2 license.

352.3 (b) If the commissioner reverses or rescinds a violation in a correction order upon
352.4 reconsideration under subdivision 2, the commissioner shall issue an amended correction
352.5 order and the license holder shall post the amended order according to paragraph (a).

352.6 (c) If the correction order is rescinded or reversed in full upon reconsideration under
352.7 subdivision 2, the license holder shall remove the original correction order posted according
352.8 to paragraph (a).

352.9 Sec. 6. Minnesota Statutes 2016, section 245A.06, is amended by adding a subdivision to
352.10 read:

352.11 Subd. 9. **Child care correction order quotas prohibited.** The commissioner and county
352.12 licensing agencies shall not order, mandate, require, or suggest to any person responsible
352.13 for licensing or inspecting a licensed family child care provider or child care center a quota
352.14 for the issuance of correction orders on a daily, weekly, monthly, quarterly, or yearly basis.

352.15 Sec. 7. **[245A.065] CHILD CARE FIX-IT TICKET.**

352.16 (a) In lieu of a correction order under section 245A.06, the commissioner shall issue a
352.17 fix-it ticket to a family child care or child care center license holder if the commissioner
352.18 finds that:

352.19 (1) the license holder has failed to comply with a requirement in this chapter or Minnesota
352.20 Rules, chapter 9502 or 9503, that the commissioner determines to be eligible for a fix-it
352.21 ticket;

352.22 (2) the violation does not imminently endanger the health, safety, or rights of the persons
352.23 served by the program;

352.24 (3) the license holder did not receive a fix-it ticket or correction order for the violation
352.25 at the license holder's last licensing inspection;

352.26 (4) the violation can be corrected at the time of inspection or within 48 hours, excluding
352.27 Saturdays, Sundays, and holidays; and

352.28 (5) the license holder corrects the violation at the time of inspection or agrees to correct
352.29 the violation within 48 hours, excluding Saturdays, Sundays, and holidays.

352.30 (b) The fix-it ticket must state:

352.31 (1) the conditions that constitute a violation of the law or rule;

353.1 (2) the specific law or rule violated; and

353.2 (3) that the violation was corrected at the time of inspection or must be corrected within
353.3 48 hours, excluding Saturdays, Sundays, and holidays.

353.4 (c) The commissioner shall not publicly publish a fix-it ticket on the department's Web
353.5 site.

353.6 (d) Within 48 hours, excluding Saturdays, Sundays, and holidays, of receiving a fix-it
353.7 ticket, the license holder must correct the violation and within one week submit evidence
353.8 to the licensing agency that the violation was corrected.

353.9 (e) If the violation is not corrected at the time of inspection or within 48 hours, excluding
353.10 Saturdays, Sundays, and holidays, or the evidence submitted is insufficient to establish that
353.11 the license holder corrected the violation, the commissioner must issue a correction order
353.12 for the violation of Minnesota law or rule identified in the fix-it ticket according to section
353.13 245A.06.

353.14 (f) The commissioner shall, following consultation with family child care license holders,
353.15 child care center license holders, and county agencies, issue a report by October 1, 2017,
353.16 that identifies the violations of this chapter and Minnesota Rules, chapters 9502 and 9503,
353.17 that are eligible for a fix-it ticket. The commissioner shall provide the report to county
353.18 agencies and the chairs and ranking minority members of the legislative committees with
353.19 jurisdiction over child care, and shall post the report to the department's Web site.

353.20 **EFFECTIVE DATE.** This section is effective October 1, 2017.

353.21 Sec. 8. Minnesota Statutes 2016, section 245A.07, subdivision 3, is amended to read:

353.22 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend
353.23 or revoke a license, or impose a fine if:

353.24 (1) a license holder fails to comply fully with applicable laws or rules;

353.25 (2) a license holder, a controlling individual, or an individual living in the household
353.26 where the licensed services are provided or is otherwise subject to a background study has
353.27 a disqualification which has not been set aside under section 245C.22;

353.28 (3) a license holder knowingly withholds relevant information from or gives false or
353.29 misleading information to the commissioner in connection with an application for a license,
353.30 in connection with the background study status of an individual, during an investigation,
353.31 or regarding compliance with applicable laws or rules; or

354.1 (4) after July 1, 2012, and upon request by the commissioner, a license holder fails to
354.2 submit the information required of an applicant under section 245A.04, subdivision 1,
354.3 paragraph (f) or (g).

354.4 A license holder who has had a license suspended, revoked, or has been ordered to pay
354.5 a fine must be given notice of the action by certified mail or personal service. If mailed, the
354.6 notice must be mailed to the address shown on the application or the last known address of
354.7 the license holder. The notice must state the reasons the license was suspended, revoked,
354.8 or a fine was ordered.

354.9 (b) If the license was suspended or revoked, the notice must inform the license holder
354.10 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
354.11 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
354.12 a license. The appeal of an order suspending or revoking a license must be made in writing
354.13 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
354.14 the commissioner within ten calendar days after the license holder receives notice that the
354.15 license has been suspended or revoked. If a request is made by personal service, it must be
354.16 received by the commissioner within ten calendar days after the license holder received the
354.17 order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a
354.18 timely appeal of an order suspending or revoking a license, the license holder may continue
354.19 to operate the program as provided in section 245A.04, subdivision 7, paragraphs (g) and
354.20 (h), until the commissioner issues a final order on the suspension or revocation.

354.21 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the license
354.22 holder of the responsibility for payment of fines and the right to a contested case hearing
354.23 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an
354.24 order to pay a fine must be made in writing by certified mail or personal service. If mailed,
354.25 the appeal must be postmarked and sent to the commissioner within ten calendar days after
354.26 the license holder receives notice that the fine has been ordered. If a request is made by
354.27 personal service, it must be received by the commissioner within ten calendar days after
354.28 the license holder received the order.

354.29 (2) The license holder shall pay the fines assessed on or before the payment date specified.
354.30 If the license holder fails to fully comply with the order, the commissioner may issue a
354.31 second fine or suspend the license until the license holder complies. If the license holder
354.32 receives state funds, the state, county, or municipal agencies or departments responsible for
354.33 administering the funds shall withhold payments and recover any payments made while the
354.34 license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine
354.35 until the commissioner issues a final order.

355.1 (3) A license holder shall promptly notify the commissioner of human services, in writing,
355.2 when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the
355.3 commissioner determines that a violation has not been corrected as indicated by the order
355.4 to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify
355.5 the license holder by certified mail or personal service that a second fine has been assessed.
355.6 The license holder may appeal the second fine as provided under this subdivision.

355.7 (4) Fines shall be assessed as follows:

355.8 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a
355.9 child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557
355.10 for which the license holder is determined responsible for the maltreatment under section
355.11 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c);

355.12 (ii) if the commissioner determines that a determination of maltreatment for which the
355.13 license holder is responsible is the result of maltreatment that meets the definition of serious
355.14 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
355.15 \$5,000;

355.16 (iii) for a program that operates out of the license holder's home and a program licensed
355.17 under Minnesota Rules, parts 9502.0300 to 9502.0495, the fine assessed against the license
355.18 holder shall not exceed \$1,000 for each determination of maltreatment;

355.19 (iv) the license holder shall forfeit \$200 for each occurrence of a violation of law or rule
355.20 governing matters of health, safety, or supervision, including but not limited to the provision
355.21 of adequate staff-to-child or adult ratios, and failure to comply with background study
355.22 requirements under chapter 245C; and

355.23 (v) the license holder shall forfeit \$100 for each occurrence of a violation of law or rule
355.24 other than those subject to a \$5,000, \$1,000, or \$200 fine above in items (i) to (iv).

355.25 For purposes of this section, "occurrence" means each violation identified in the
355.26 commissioner's fine order. Fines assessed against a license holder that holds a license to
355.27 provide home and community-based services, as identified in section 245D.03, subdivision
355.28 1, and a community residential setting or day services facility license under chapter 245D
355.29 where the services are provided, may be assessed against both licenses for the same
355.30 occurrence, but the combined amount of the fines shall not exceed the amount specified in
355.31 this clause for that occurrence.

355.32 (5) When a fine has been assessed, the license holder may not avoid payment by closing,
355.33 selling, or otherwise transferring the licensed program to a third party. In such an event, the

356.1 license holder will be personally liable for payment. In the case of a corporation, each
356.2 controlling individual is personally and jointly liable for payment.

356.3 (d) Except for background study violations involving the failure to comply with an order
356.4 to immediately remove an individual or an order to provide continuous, direct supervision,
356.5 the commissioner shall not issue a fine under paragraph (c) relating to a background study
356.6 violation to a license holder who self-corrects a background study violation before the
356.7 commissioner discovers the violation. A license holder who has previously exercised the
356.8 provisions of this paragraph to avoid a fine for a background study violation may not avoid
356.9 a fine for a subsequent background study violation unless at least 365 days have passed
356.10 since the license holder self-corrected the earlier background study violation.

356.11 **EFFECTIVE DATE.** This section is effective August 1, 2017.

356.12 **Sec. 9. [245A.1434] INFORMATION FOR CHILD CARE LICENSE HOLDERS.**

356.13 The commissioner shall inform family child care and child care center license holders
356.14 on a timely basis of changes to state and federal statute, rule, regulation, and policy relating
356.15 to the provision of licensed child care, the child care assistance program under chapter 119B,
356.16 the quality rating and improvement system under section 124D.142, and child care licensing
356.17 functions delegated to counties. Communications under this section shall include information
356.18 to promote license holder compliance with identified changes. Communications under this
356.19 section may be accomplished by electronic means and shall be made available to the public
356.20 online.

356.21 **Sec. 10. [245A.153] REPORT TO LEGISLATURE ON THE STATUS OF CHILD**
356.22 **CARE.**

356.23 Subdivision 1. **Reporting requirements.** Beginning on February 1, 2018, and no later
356.24 than February 1 of each year thereafter, the commissioner of human services shall provide
356.25 a report on the status of child care in Minnesota to the chairs and ranking minority members
356.26 of the legislative committees with jurisdiction over child care.

356.27 Subd. 2. **Contents of report.** (a) The report must include the following:

356.28 (1) summary data on trends in child care center and family child care capacity and
356.29 availability throughout the state, including the number of centers and programs that have
356.30 opened and closed and the geographic locations of those centers and programs;

356.31 (2) a description of any changes to statutes, administrative rules, or agency policies and
356.32 procedures that were implemented in the year preceding the report;

357.1 (3) a description of the actions the department has taken to address or implement the
357.2 recommendations from the Legislative Task Force on Access to Affordable Child Care
357.3 Report dated January 15, 2017, including but not limited to actions taken in the areas of:

357.4 (i) encouraging uniformity in implementing and interpreting statutes, administrative
357.5 rules, and agency policies and procedures relating to child care licensing and access;

357.6 (ii) improving communication with county licensors and child care providers regarding
357.7 changes to statutes, administrative rules, and agency policies and procedures, ensuring that
357.8 information is directly and regularly transmitted;

357.9 (iii) providing notice to child care providers before issuing correction orders or negative
357.10 actions relating to recent changes to statutes, administrative rules, and agency policies and
357.11 procedures;

357.12 (iv) implementing confidential, anonymous communication processes for child care
357.13 providers to ask questions and receive prompt, clear answers from the department;

357.14 (v) streamlining processes to reduce duplication or overlap in paperwork and training
357.15 requirements for child care providers; and

357.16 (vi) compiling and distributing information detailing trends in the violations for which
357.17 correction orders and negative actions are issued;

357.18 (4) a description of the department's efforts to cooperate with counties while addressing
357.19 and implementing the task force recommendations;

357.20 (5) summary data on child care assistance programs including but not limited to state
357.21 funding and numbers of families served; and

357.22 (6) summary data on family child care correction orders, including:

357.23 (i) the number of licensed family child care provider appeals or requests for
357.24 reconsideration of correction orders to the Department of Human Services;

357.25 (ii) the number of family child care correction order appeals or requests for
357.26 reconsideration that the Department of Human Services grants; and

357.27 (iii) the number of family child care correction order appeals or requests for
357.28 reconsideration that the Department of Human Services denies.

357.29 (b) The commissioner may offer recommendations for legislative action.

357.30 Subd. 3. **Sunset.** This section expires February 2, 2020.

358.1 Sec. 11. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

358.2 Subd. 3c. **Local welfare agency, Department of Human Services or Department of**
 358.3 **Health responsible for assessing or investigating reports of maltreatment.** (a) The ~~county~~
 358.4 local welfare agency is the agency responsible for assessing or investigating allegations of
 358.5 maltreatment in child foster care, family child care, legally ~~unlicensed~~ nonlicensed child
 358.6 care, ~~juvenile correctional facilities licensed under section 241.021 located in the local~~
 358.7 ~~welfare agency's county~~, and reports involving children served by an unlicensed personal
 358.8 care provider organization under section 256B.0659. Copies of findings related to personal
 358.9 care provider organizations under section 256B.0659 must be forwarded to the Department
 358.10 of Human Services provider enrollment.

358.11 (b) The Department of Human Services is the agency responsible for assessing or
 358.12 investigating allegations of maltreatment in juvenile correctional facilities listed under
 358.13 section 241.021 located in the local welfare agency's county and in facilities licensed or
 358.14 certified under chapters 245A and 245D, except for child foster care and family child care.

358.15 (c) The Department of Health is the agency responsible for assessing or investigating
 358.16 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
 358.17 144A.43 to 144A.482.

358.18 ARTICLE 10

358.19 HEALTH DEPARTMENT

358.20 Section 1. Minnesota Statutes 2016, section 103I.101, subdivision 2, is amended to read:

358.21 Subd. 2. **Duties.** The commissioner shall:

358.22 (1) regulate the drilling, construction, modification, repair, and sealing of wells and
 358.23 borings;

358.24 (2) examine and license:

358.25 (i) well contractors;

358.26 (ii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

358.27 (iii) persons modifying or repairing well casings, well screens, or well diameters;

358.28 (iv) persons constructing, repairing, and sealing drive point wells or dug wells;

358.29 (v) persons installing well pumps or pumping equipment;

358.30 (vi) persons constructing, repairing, and sealing dewatering wells;

359.1 ~~(vii) persons sealing wells; persons installing well pumps or pumping equipment or~~
 359.2 ~~borings; and~~

359.3 ~~(viii) persons excavating or drilling holes for the installation of elevator borings or~~
 359.4 ~~hydraulic cylinders;~~

359.5 (3) ~~register~~ license and examine monitoring well contractors;

359.6 (4) license explorers engaged in exploratory boring and examine individuals who
 359.7 supervise or oversee exploratory boring;

359.8 (5) after consultation with the commissioner of natural resources and the Pollution
 359.9 Control Agency, establish standards for the design, location, construction, repair, and sealing
 359.10 of wells and borings within the state; and

359.11 (6) issue permits for wells, groundwater thermal devices, bored geothermal heat
 359.12 exchangers, and elevator borings.

359.13 Sec. 2. Minnesota Statutes 2016, section 103I.101, subdivision 5, is amended to read:

359.14 Subd. 5. **Commissioner to adopt rules.** The commissioner shall adopt rules including:

359.15 (1) issuance of licenses for:

359.16 (i) qualified well contractors;₂

359.17 (ii) persons modifying or repairing well casings, well screens, or well diameters;

359.18 ~~(ii)~~ (iii) persons constructing, repairing, and sealing drive point wells or dug wells;

359.19 ~~(iii)~~ (iv) persons constructing, repairing, and sealing dewatering wells;

359.20 ~~(iv)~~ (v) persons sealing wells or borings;

359.21 ~~(v)~~ (vi) persons installing well pumps or pumping equipment;

359.22 ~~(vi)~~ (vii) persons constructing, repairing, and sealing bored geothermal heat exchangers;

359.23 and

359.24 ~~(vii)~~ (viii) persons constructing, repairing, and sealing elevator borings;

359.25 (2) issuance of ~~registration~~ licenses for monitoring well contractors;

359.26 (3) establishment of conditions for examination and review of applications for license
 359.27 and ~~registration~~ certification;

359.28 (4) establishment of conditions for revocation and suspension of license and ~~registration~~
 359.29 certification;

360.1 (5) establishment of minimum standards for design, location, construction, repair, and
360.2 sealing of wells and borings to implement the purpose and intent of this chapter;

360.3 (6) establishment of a system for reporting on wells and borings drilled and sealed;

360.4 (7) establishment of standards for the construction, maintenance, sealing, and water
360.5 quality monitoring of wells in areas of known or suspected contamination;

360.6 (8) establishment of wellhead protection measures for wells serving public water supplies;

360.7 (9) establishment of procedures to coordinate collection of well and boring data with
360.8 other state and local governmental agencies;

360.9 (10) establishment of criteria and procedures for submission of well and boring logs,
360.10 formation samples or well or boring cuttings, water samples, or other special information
360.11 required for and water resource mapping; and

360.12 (11) establishment of minimum standards for design, location, construction, maintenance,
360.13 repair, sealing, safety, and resource conservation related to borings, including exploratory
360.14 borings as defined in section 103I.005, subdivision 9.

360.15 Sec. 3. Minnesota Statutes 2016, section 103I.111, subdivision 6, is amended to read:

360.16 Subd. 6. **Unsealed wells and borings are public health nuisances.** A well or boring
360.17 that is required to be sealed under section 103I.301 but is not sealed is a public health
360.18 nuisance. A county may abate the unsealed well or boring with the same authority of a
360.19 community health board to abate a public health nuisance under section 145A.04, subdivision
360.20 8.

360.21 Sec. 4. Minnesota Statutes 2016, section 103I.111, subdivision 7, is amended to read:

360.22 Subd. 7. **Local license ~~or registration~~ fees prohibited.** (a) A political subdivision may
360.23 not require a licensed well contractor to pay a license ~~or registration~~ fee.

360.24 (b) The commissioner of health must provide a political subdivision with a list of licensed
360.25 well contractors upon request.

360.26 Sec. 5. Minnesota Statutes 2016, section 103I.111, subdivision 8, is amended to read:

360.27 Subd. 8. **Municipal regulation of drilling.** A municipality may regulate all drilling,
360.28 except well, elevator ~~shaft~~ boring, and exploratory drilling that is subject to the provisions
360.29 of this chapter, above, in, through, and adjacent to subsurface areas designated for mined

361.1 underground space development and existing mined underground space. The regulations
361.2 may prohibit, restrict, control, and require permits for the drilling.

361.3 Sec. 6. Minnesota Statutes 2016, section 103I.205, is amended to read:

361.4 **103I.205 WELL AND BORING CONSTRUCTION.**

361.5 Subdivision 1. **Notification required.** (a) Except as provided in paragraphs (d) and (e),
361.6 a person may not construct a well until a notification of the proposed well on a form
361.7 prescribed by the commissioner is filed with the commissioner with the filing fee in section
361.8 103I.208, and, when applicable, the person has met the requirements of paragraph (f). If
361.9 after filing the well notification an attempt to construct a well is unsuccessful, a new
361.10 notification is not required unless the information relating to the successful well has
361.11 substantially changed.

361.12 (b) The property owner, the property owner's agent, or the ~~well~~ licensed contractor where
361.13 a well is to be located must file the well notification with the commissioner.

361.14 (c) The well notification under this subdivision preempts local permits and notifications,
361.15 and counties or home rule charter or statutory cities may not require a permit or notification
361.16 for wells unless the commissioner has delegated the permitting or notification authority
361.17 under section 103I.111.

361.18 (d) A person who is an individual that constructs a drive point water-supply well on
361.19 property owned or leased by the individual for farming or agricultural purposes or as the
361.20 individual's place of abode must notify the commissioner of the installation and location of
361.21 the well. The person must complete the notification form prescribed by the commissioner
361.22 and mail it to the commissioner by ten days after the well is completed. A fee may not be
361.23 charged for the notification. A person who sells drive point wells at retail must provide
361.24 buyers with notification forms and informational materials including requirements regarding
361.25 wells, their location, construction, and disclosure. The commissioner must provide the
361.26 notification forms and informational materials to the sellers.

361.27 (e) A person may not construct a monitoring well until a permit is issued by the
361.28 commissioner for the construction. If after obtaining a permit an attempt to construct a well
361.29 is unsuccessful, a new permit is not required as long as the initial permit is modified to
361.30 indicate the location of the successful well.

361.31 (f) When the operation of a well will require an appropriation permit from the
361.32 commissioner of natural resources, a person may not begin construction of the well until
361.33 the person submits the following information to the commissioner of natural resources:

362.1 (1) the location of the well;

362.2 (2) the formation or aquifer that will serve as the water source;

362.3 (3) the maximum daily, seasonal, and annual pumpage rates and volumes that will be
362.4 requested in the appropriation permit; and

362.5 (4) other information requested by the commissioner of natural resources that is necessary
362.6 to conduct the preliminary assessment required under section 103G.287, subdivision 1,
362.7 paragraph (c).

362.8 The person may begin construction after receiving preliminary approval from the
362.9 commissioner of natural resources.

362.10 Subd. 2. **Emergency permit and notification exemptions.** The commissioner may
362.11 adopt rules that modify the procedures for filing a well or boring notification or well or
362.12 boring permit if conditions occur that:

362.13 (1) endanger the public health and welfare or cause a need to protect the groundwater;
362.14 or

362.15 (2) require the monitoring well contractor, limited well/boring contractor, or well
362.16 contractor to begin constructing a well before obtaining a permit or notification.

362.17 Subd. 3. **Maintenance permit.** (a) Except as provided under paragraph (b), a well that
362.18 is not in use must be sealed or have a maintenance permit.

362.19 (b) If a monitoring well or a dewatering well is not sealed by 14 months after completion
362.20 of construction, the owner of the property on which the well is located must obtain and
362.21 annually renew a maintenance permit from the commissioner.

362.22 Subd. 4. **License required.** (a) Except as provided in paragraph (b), (c), (d), or (e),
362.23 section 103I.401, subdivision 2, or 103I.601, subdivision 2, a person may not drill, construct,
362.24 repair, or seal a well or boring unless the person has a well contractor's license in possession.

362.25 (b) A person may construct, repair, and seal a monitoring well if the person:

362.26 (1) is a professional engineer licensed under sections 326.02 to 326.15 in the branches
362.27 of civil or geological engineering;

362.28 (2) is a hydrologist or hydrogeologist certified by the American Institute of Hydrology;

362.29 (3) is a professional geoscientist licensed under sections 326.02 to 326.15;

362.30 (4) is a geologist certified by the American Institute of Professional Geologists; or

362.31 (5) meets the qualifications established by the commissioner in rule.

363.1 A person must ~~register with~~ be licensed by the commissioner as a monitoring well
363.2 contractor on forms provided by the commissioner.

363.3 (c) A person may do the following work with a limited well/boring contractor's license
363.4 in possession. A separate license is required for each of the six activities:

363.5 (1) installing or repairing well screens or pitless units or pitless adaptors and well casings
363.6 from the pitless adaptor or pitless unit to the upper termination of the well casing;

363.7 (2) constructing, repairing, and sealing drive point wells or dug wells;

363.8 (3) installing well pumps or pumping equipment;

363.9 (4) sealing wells or borings;

363.10 (5) constructing, repairing, or sealing dewatering wells; or

363.11 (6) constructing, repairing, or sealing bored geothermal heat exchangers.

363.12 (d) A person may construct, repair, and seal an elevator boring with an elevator boring
363.13 contractor's license.

363.14 (e) Notwithstanding other provisions of this chapter requiring a license ~~or registration~~,
363.15 a license ~~or registration~~ is not required for a person who complies with the other provisions
363.16 of this chapter if the person is:

363.17 (1) an individual who constructs a well on land that is owned or leased by the individual
363.18 and is used by the individual for farming or agricultural purposes or as the individual's place
363.19 of abode;

363.20 (2) an individual who performs labor or services for a contractor licensed ~~or registered~~
363.21 under the provisions of this chapter in connection with the construction, sealing, or repair
363.22 of a well or boring at the direction and under the personal supervision of a contractor licensed
363.23 ~~or registered~~ under the provisions of this chapter; or

363.24 (3) a licensed plumber who is repairing submersible pumps or water pipes associated
363.25 with well water systems if: (i) the repair location is within an area where there is no licensed
363.26 ~~or registered~~ well contractor within 50 miles, and (ii) the licensed plumber complies with
363.27 all relevant sections of the plumbing code.

363.28 Subd. 5. **At-grade monitoring wells.** At-grade monitoring wells are authorized without
363.29 variance and may be installed for the purpose of evaluating groundwater conditions or for
363.30 use as a leak detection device. An at-grade monitoring well must be installed in accordance
363.31 with the rules of the commissioner. The at-grade monitoring wells must be installed with

364.1 an impermeable double locking cap approved by the commissioner and must be labeled
364.2 monitoring wells.

364.3 Subd. 6. **Distance requirements for sources of contamination, buildings, gas pipes,**
364.4 **liquid propane tanks, and electric lines.** (a) A person may not place, construct, or install
364.5 an actual or potential source of contamination, building, gas pipe, liquid propane tank, or
364.6 electric line any closer to a well or boring than the isolation distances prescribed by the
364.7 commissioner by rule unless a variance has been prescribed by rule.

364.8 (b) The commissioner shall establish by rule reduced isolation distances for facilities
364.9 which have safeguards in accordance with sections 18B.01, subdivision 26, and 18C.005,
364.10 subdivision 29.

364.11 Subd. 7. **Well identification label required.** After a well has been constructed, the
364.12 person constructing the well must attach a label to the well showing the unique well number.

364.13 Subd. 8. **Wells on property of another.** A person may not construct or have constructed
364.14 a well for the person's own use on the property of another until the owner of the property
364.15 on which the well is to be located and the intended well user sign a written agreement that
364.16 identifies which party will be responsible for obtaining all permits or filing notification,
364.17 paying applicable fees and for sealing the well. If the property owner refuses to sign the
364.18 agreement, the intended well user may, in lieu of a written agreement, state in writing to
364.19 the commissioner that the well user will be responsible for obtaining permits, filing
364.20 notification, paying applicable fees, and sealing the well. Nothing in this subdivision
364.21 eliminates the responsibilities of the property owner under this chapter, or allows a person
364.22 to construct a well on the property of another without consent or other legal authority.

364.23 Subd. 9. **Report of work.** Within 30 days after completion or sealing of a well or boring,
364.24 the person doing the work must submit a verified report to the commissioner containing the
364.25 information specified by rules adopted under this chapter.

364.26 Within 30 days after receiving the report, the commissioner shall send or otherwise
364.27 provide access to a copy of the report to the commissioner of natural resources, to the local
364.28 soil and water conservation district where the well is located, and to the director of the
364.29 Minnesota Geological Survey.

364.30 Sec. 7. Minnesota Statutes 2016, section 103I.301, is amended to read:

364.31 **103I.301 WELL AND BORING SEALING REQUIREMENTS.**

364.32 Subdivision 1. **Wells and borings.** (a) A property owner must have a well or boring
364.33 sealed if:

365.1 (1) the well or boring is contaminated or may contribute to the spread of contamination;

365.2 (2) the well or boring was attempted to be sealed but was not sealed according to the
365.3 provisions of this chapter; or

365.4 (3) the well or boring is located, constructed, or maintained in a manner that its continued
365.5 use or existence endangers groundwater quality or is a safety or health hazard.

365.6 (b) A well or boring that is not in use must be sealed unless the property owner has a
365.7 maintenance permit for the well.

365.8 (c) The property owner must have a well or boring sealed by a ~~registered~~ or licensed
365.9 person authorized to seal the well or boring, consistent with provisions of this chapter.

365.10 Subd. 2. **Monitoring wells.** The owner of the property where a monitoring well is located
365.11 must have the monitoring well sealed when the well is no longer in use. The owner must
365.12 have a well contractor, limited well/boring sealing contractor, or a monitoring well contractor
365.13 seal the monitoring well.

365.14 Subd. 3. **Dewatering wells.** (a) The owner of the property where a dewatering well is
365.15 located must have the dewatering well sealed when the dewatering well is no longer in use.

365.16 (b) A well contractor, limited well/boring sealing contractor, or limited dewatering well
365.17 contractor shall seal the dewatering well.

365.18 Subd. 4. **Sealing procedures.** Wells and borings must be sealed according to rules
365.19 adopted by the commissioner.

365.20 Subd. 6. **Notification required.** A person may not seal a well until a notification of the
365.21 proposed sealing is filed as prescribed by the commissioner.

365.22 Sec. 8. Minnesota Statutes 2016, section 103I.501, is amended to read:

365.23 **103I.501 LICENSING AND REGULATION OF WELLS AND BORINGS.**

365.24 (a) The commissioner shall regulate and license:

365.25 (1) drilling, constructing, and repair of wells;

365.26 (2) sealing of wells;

365.27 (3) installing of well pumps and pumping equipment;

365.28 (4) excavating, drilling, repairing, and sealing of elevator borings;

365.29 (5) construction, repair, and sealing of environmental bore holes; and

365.30 (6) construction, repair, and sealing of bored geothermal heat exchangers.

366.1 (b) The commissioner shall examine and license well contractors, limited well/boring
366.2 contractors, ~~and~~ elevator boring contractors, and ~~examine and register~~ monitoring well
366.3 contractors.

366.4 (c) The commissioner shall license explorers engaged in exploratory boring and shall
366.5 examine persons who supervise or oversee exploratory boring.

366.6 Sec. 9. Minnesota Statutes 2016, section 103I.505, is amended to read:

366.7 **103I.505 RECIPROCITY OF LICENSES AND REGISTRATIONS**
366.8 **CERTIFICATIONS.**

366.9 Subdivision 1. **Reciprocity authorized.** The commissioner may issue a license or ~~register~~
366.10 certify a person under this chapter, without giving an examination, if the person is licensed
366.11 or ~~registered~~ certified in another state and:

366.12 (1) the requirements for licensing or ~~registration~~ certification under which the well or
366.13 boring contractor was licensed or ~~registered~~ person was certified do not conflict with this
366.14 chapter;

366.15 (2) the requirements are of a standard not lower than that specified by the rules adopted
366.16 under this chapter; and

366.17 (3) equal reciprocal privileges are granted to licensees or ~~registrants~~ certified persons
366.18 of this state.

366.19 Subd. 2. **Fees required.** A well or boring contractor or certified person must apply for
366.20 the license or ~~registration~~ certification and pay the fees under the provisions of this chapter
366.21 to receive a license or ~~registration~~ certification under this section.

366.22 Sec. 10. Minnesota Statutes 2016, section 103I.515, is amended to read:

366.23 **103I.515 LICENSES NOT TRANSFERABLE.**

366.24 A license or ~~registration~~ certification issued under this chapter is not transferable.

366.25 Sec. 11. Minnesota Statutes 2016, section 103I.535, subdivision 3, is amended to read:

366.26 Subd. 3. **Certification examination.** After the commissioner has approved the
366.27 application, the applicant must take an examination given by the commissioner.

367.1 Sec. 12. Minnesota Statutes 2016, section 103I.535, is amended by adding a subdivision
367.2 to read:

367.3 Subd. 3b. **Certification renewal.** (a) A representative must file an application and a
367.4 renewal application fee to renew the certification by the date stated in the certification.

367.5 (b) The renewal application must include information that the certified representative
367.6 has met continuing education requirements established by the commissioner by rule.

367.7 Sec. 13. Minnesota Statutes 2016, section 103I.535, subdivision 6, is amended to read:

367.8 Subd. 6. **License fee.** The fee for an elevator ~~shaft~~ boring contractor's license is \$75.

367.9 Sec. 14. Minnesota Statutes 2016, section 103I.541, is amended to read:

367.10 **103I.541 MONITORING WELL CONTRACTOR'S REGISTRATION LICENSE;**
367.11 **REPRESENTATIVE'S CERTIFICATION.**

367.12 Subdivision 1. **Registration Certification.** A person seeking ~~registration as~~ certification
367.13 to represent a monitoring well contractor must meet examination and experience requirements
367.14 adopted by the commissioner by rule.

367.15 Subd. 2. **Validity.** A monitoring well contractor's ~~registration~~ certification is valid until
367.16 the date prescribed in the ~~registration~~ certification by the commissioner.

367.17 Subd. 2a. **Certification application.** (a) An individual must submit an application and
367.18 application fee to the commissioner to apply for certification as a representative of a
367.19 monitoring well contractor.

367.20 (b) The application must be on forms prescribed by the commissioner. The application
367.21 must state the applicant's qualifications for the certification, and other information required
367.22 by the commissioner.

367.23 ~~Subd. 2b. **Issuance of registration.** If a person employs a certified representative,~~
367.24 ~~submits the bond under subdivision 3, and pays the registration fee of \$75 for a monitoring~~
367.25 ~~well contractor registration, the commissioner shall issue a monitoring well contractor~~
367.26 ~~registration to the applicant. The fee for an individual registration is \$75. The commissioner~~
367.27 ~~may not act on an application until the application fee is paid.~~

367.28 Subd. 2c. **Certification fee.** (a) The application fee for certification as a representative
367.29 of a monitoring well contractor is \$75. The commissioner may not act on an application
367.30 until the application fee is paid.

368.1 (b) The renewal fee for certification as a representative of a monitoring well contractor
368.2 is \$75. The commissioner may not renew a certification until the renewal fee is paid.

368.3 Subd. 2d. **Examination.** After the commissioner has approved an application, the
368.4 applicant must take an examination given by the commissioner.

368.5 Subd. 2e. **Issuance of certification.** If the applicant meets the experience requirements
368.6 established by rule and passes the examination as determined by the commissioner, the
368.7 commissioner shall issue the applicant a certification to represent a monitoring well
368.8 contractor.

368.9 Subd. 2f. **Certification renewal.** (a) A representative must file an application and a
368.10 renewal application fee to renew the certification by the date stated in the certification.

368.11 (b) The renewal application must include information that the certified representative
368.12 has met continuing education requirements established by the commissioner by rule.

368.13 Subd. 2g. **Issuance of license.** (a) If a person employs a certified representative, submits
368.14 the bond under subdivision 3, and pays the license fee of \$75 for a monitoring well contractor
368.15 license, the commissioner shall issue a monitoring well contractor license to the applicant.

368.16 (b) The commissioner may not act on an application until the application fee is paid.

368.17 Subd. 3. **Bond.** (a) As a condition of being issued a monitoring well contractor's
368.18 ~~registration~~ license, the applicant must submit a corporate surety bond for \$10,000 approved
368.19 by the commissioner. The bond must be conditioned to pay the state on performance of
368.20 work in this state that is not in compliance with this chapter or rules adopted under this
368.21 chapter. The bond is in lieu of other license bonds required by a political subdivision of the
368.22 state.

368.23 (b) From proceeds of the bond, the commissioner may compensate persons injured or
368.24 suffering financial loss because of a failure of the applicant to perform work or duties in
368.25 compliance with this chapter or rules adopted under this chapter.

368.26 Subd. 4. **License renewal.** (a) A person must file an application and a renewal application
368.27 fee to renew the ~~registration~~ license by the date stated in the ~~registration~~ license.

368.28 (b) The renewal application fee for a monitoring well contractor's ~~registration~~ license is
368.29 \$75.

368.30 (c) The renewal application must include information that the certified representative
368.31 of the applicant has met continuing education requirements established by the commissioner
368.32 by rule.

369.1 (d) At the time of the renewal, the commissioner must have on file all well and boring
369.2 construction reports, well and boring sealing reports, well permits, and notifications for
369.3 work conducted by the ~~registered~~ licensed person since the last ~~registration~~ license renewal.

369.4 Subd. 5. **Incomplete or late renewal.** If a ~~registered~~ licensed person submits a renewal
369.5 application after the required renewal date:

369.6 (1) the ~~registered~~ licensed person must include a late fee of \$75; and

369.7 (2) the ~~registered~~ licensed person may not conduct activities authorized by the monitoring
369.8 well contractor's ~~registration~~ license until the renewal application, renewal application fee,
369.9 late fee, and all other information required in subdivision 4 are submitted.

369.10 Sec. 15. Minnesota Statutes 2016, section 103I.545, subdivision 1, is amended to read:

369.11 Subdivision 1. **Drilling machine.** (a) A person may not use a drilling machine such as
369.12 a cable tool, rotary tool, hollow rod tool, or auger for a drilling activity requiring a license
369.13 ~~or registration~~ under this chapter unless the drilling machine is registered with the
369.14 commissioner.

369.15 (b) A person must apply for the registration on forms prescribed by the commissioner
369.16 and submit a \$75 registration fee.

369.17 (c) A registration is valid for one year.

369.18 Sec. 16. Minnesota Statutes 2016, section 103I.545, subdivision 2, is amended to read:

369.19 Subd. 2. **Hoist.** (a) A person may not use a machine such as a hoist for an activity
369.20 requiring a license ~~or registration~~ under this chapter to repair wells or borings, seal wells
369.21 or borings, or install pumps unless the machine is registered with the commissioner.

369.22 (b) A person must apply for the registration on forms prescribed by the commissioner
369.23 and submit a \$75 registration fee.

369.24 (c) A registration is valid for one year.

369.25 Sec. 17. Minnesota Statutes 2016, section 103I.711, subdivision 1, is amended to read:

369.26 Subdivision 1. **Impoundment.** The commissioner may apply to district court for a
369.27 warrant authorizing seizure and impoundment of all drilling machines or hoists owned or
369.28 used by a person. The court shall issue an impoundment order upon the commissioner's
369.29 showing that a person is constructing, repairing, or sealing wells or borings or installing
369.30 pumps or pumping equipment or excavating holes for installing elevator ~~shafts~~ borings

370.1 without a license ~~or registration~~ as required under this chapter. A sheriff on receipt of the
 370.2 warrant must seize and impound all drilling machines and hoists owned or used by the
 370.3 person. A person from whom equipment is seized under this subdivision may file an action
 370.4 in district court for the purpose of establishing that the equipment was wrongfully seized.

370.5 Sec. 18. Minnesota Statutes 2016, section 103I.715, subdivision 2, is amended to read:

370.6 Subd. 2. **Gross misdemeanors.** A person is guilty of a gross misdemeanor who:

370.7 (1) willfully violates a provision of this chapter or order of the commissioner;

370.8 (2) engages in the business of drilling or making wells, sealing wells, installing pumps
 370.9 or pumping equipment, or constructing elevator ~~shafts~~ borings without a license required
 370.10 by this chapter; or

370.11 (3) engages in the business of exploratory boring without an exploratory borer's license
 370.12 under this chapter.

370.13 Sec. 19. [144.059] PALLIATIVE CARE ADVISORY COUNCIL.

370.14 Subdivision 1. Membership. The Palliative Care Advisory Council shall consist of 18
 370.15 public members.

370.16 Subd. 2. Public members. (a) The commissioner shall appoint, in the manner provided
 370.17 in section 15.0597, 18 public members, including the following:

370.18 (1) two physicians, of which one is certified by the American Board of Hospice and
 370.19 Palliative Medicine;

370.20 (2) two registered nurses or advanced practice registered nurses, of which one is certified
 370.21 by the National Board for Certification of Hospice and Palliative Nurses;

370.22 (3) one care coordinator experienced in working with people with serious or chronic
 370.23 illness and their families;

370.24 (4) one spiritual counselor experienced in working with people with serious or chronic
 370.25 illness and their families;

370.26 (5) three licensed health professionals, such as complementary and alternative health
 370.27 care practitioners, dietitians or nutritionists, pharmacists, or physical therapists, who are
 370.28 neither physicians nor nurses, but who have experience as members of a palliative care
 370.29 interdisciplinary team working with people with serious or chronic illness and their families;

371.1 (6) one licensed social worker experienced in working with people with serious or chronic
371.2 illness and their families;

371.3 (7) four patients or personal caregivers experienced with serious or chronic illness;

371.4 (8) one representative of a health plan company;

371.5 (9) one physician assistant that is a member of the American Academy of Hospice and
371.6 Palliative Medicine; and

371.7 (10) two members from any of the categories described in clauses (1) to (9).

371.8 (b) Council membership must include, where possible, representation that is racially,
371.9 culturally, linguistically, geographically, and economically diverse.

371.10 (c) The council must include at least six members who reside outside Anoka, Carver,
371.11 Chisago, Dakota, Hennepin, Isanti, Mille Lacs, Ramsey, Scott, Sherburne, Sibley, Stearns,
371.12 Washington, or Wright Counties.

371.13 (d) To the extent possible, council membership must include persons who have experience
371.14 in palliative care research, palliative care instruction in a medical or nursing school setting,
371.15 palliative care services for veterans as a provider or recipient, or pediatric care.

371.16 (e) Council membership must include health professionals who have palliative care work
371.17 experience or expertise in palliative care delivery models in a variety of inpatient, outpatient,
371.18 and community settings, including acute care, long-term care, or hospice, with a variety of
371.19 populations, including pediatric, youth, and adult patients.

371.20 Subd. 3. **Term.** Members of the council shall serve for a term of three years and may
371.21 be reappointed. Members shall serve until their successors have been appointed.

371.22 Subd. 4. **Administration.** The commissioner or the commissioner's designee shall
371.23 provide meeting space and administrative services for the council.

371.24 Subd. 5. **Chairs.** At the council's first meeting, and biannually thereafter, the members
371.25 shall elect a chair and a vice-chair whose duties shall be established by the council.

371.26 Subd. 6. **Meeting.** The council shall meet at least twice yearly.

371.27 Subd. 7. **No compensation.** Public members of the council serve without compensation
371.28 or reimbursement for expenses.

371.29 Subd. 8. **Duties.** (a) The council shall consult with and advise the commissioner on
371.30 matters related to the establishment, maintenance, operation, and outcomes evaluation of
371.31 palliative care initiatives in the state.

372.1 (b) By February 15 of each year, the council shall submit to the chairs and ranking
 372.2 minority members of the committees of the senate and the house of representatives with
 372.3 primary jurisdiction over health care a report containing:

372.4 (1) the advisory council's assessment of the availability of palliative care in the state;

372.5 (2) the advisory council's analysis of barriers to greater access to palliative care; and

372.6 (3) recommendations for legislative action, with draft legislation to implement the
 372.7 recommendations.

372.8 (c) The Department of Health shall publish the report each year on the department's Web
 372.9 site.

372.10 Subd. 9. **Open meetings.** The council is subject to the requirements of chapter 13D.

372.11 Subd. 10. **Sunset.** The council shall sunset January 1, 2025.

372.12 Sec. 20. **[144.1215] AUTHORIZATION TO USE HANDHELD DENTAL X-RAY**
 372.13 **EQUIPMENT.**

372.14 Subdivision 1. **Definition; handheld dental x-ray equipment.** For purposes of this
 372.15 section, "handheld dental x-ray equipment" means x-ray equipment that is used to take
 372.16 dental radiographs, is designed to be handheld during operation, and is operated by an
 372.17 individual authorized to take dental radiographs under chapter 150A.

372.18 Subd. 2. **Use authorized.** (a) Handheld dental x-ray equipment may be used if the
 372.19 equipment:

372.20 (1) has been approved for human use by the United States Food and Drug Administration
 372.21 and is being used in a manner consistent with that approval; and

372.22 (2) utilizes a backscatter shield that:

372.23 (i) is composed of a leaded polymer or a substance with a substantially equivalent
 372.24 protective capacity;

372.25 (ii) has at least 0.25 millimeters of lead or lead-shielding equivalent; and

372.26 (iii) is permanently affixed to the handheld dental x-ray equipment.

372.27 (b) The use of handheld dental x-ray equipment is prohibited if the equipment's
 372.28 backscatter shield is broken or not permanently affixed to the system.

372.29 (c) The use of handheld dental x-ray equipment shall not be limited to situations in which
 372.30 it is impractical to transfer the patient to a stationary x-ray system.

373.1 (d) Handheld dental x-ray equipment must be stored when not in use, by being secured
373.2 in a restricted, locked area of the facility.

373.3 (e) Handheld dental x-ray equipment must be calibrated initially and at intervals that
373.4 must not exceed 24 months. Calibration must include the test specified in Minnesota Rules,
373.5 part 4732.1100, subpart 11.

373.6 (f) Notwithstanding Minnesota Rules, part 4732.0880, subpart 2, item C, the tube housing
373.7 and the position-indicating device of handheld dental x-ray equipment may be handheld
373.8 during an exposure.

373.9 Subd. 3. Exemptions from certain shielding requirements. Handheld dental x-ray
373.10 equipment used according to this section and according to manufacturer instructions is
373.11 exempt from the following requirements for the equipment:

373.12 (1) shielding requirements in Minnesota Rules, part 4732.0365, item B; and

373.13 (2) requirements for the location of the x-ray control console or utilization of a protective
373.14 barrier in Minnesota Rules, part 4732.0800, subpart 2, item B, subitems (2) and (3), provided
373.15 the equipment utilizes a backscatter shield that satisfies the requirements in subdivision 2,
373.16 paragraph (a), clause (2).

373.17 Subd. 4. Compliance with rules. A registrant using handheld dental x-ray equipment
373.18 shall otherwise comply with Minnesota Rules, chapter 4732.

373.19 Sec. 21. Minnesota Statutes 2016, section 144.122, is amended to read:

373.20 **144.122 LICENSE, PERMIT, AND SURVEY FEES.**

373.21 (a) The state commissioner of health, by rule, may prescribe procedures and fees for
373.22 filing with the commissioner as prescribed by statute and for the issuance of original and
373.23 renewal permits, licenses, registrations, and certifications issued under authority of the
373.24 commissioner. The expiration dates of the various licenses, permits, registrations, and
373.25 certifications as prescribed by the rules shall be plainly marked thereon. Fees may include
373.26 application and examination fees and a penalty fee for renewal applications submitted after
373.27 the expiration date of the previously issued permit, license, registration, and certification.
373.28 The commissioner may also prescribe, by rule, reduced fees for permits, licenses,
373.29 registrations, and certifications when the application therefor is submitted during the last
373.30 three months of the permit, license, registration, or certification period. Fees proposed to
373.31 be prescribed in the rules shall be first approved by the Department of Management and
373.32 Budget. All fees proposed to be prescribed in rules shall be reasonable. The fees shall be
373.33 in an amount so that the total fees collected by the commissioner will, where practical,

374.1 approximate the cost to the commissioner in administering the program. All fees collected
 374.2 shall be deposited in the state treasury and credited to the state government special revenue
 374.3 fund unless otherwise specifically appropriated by law for specific purposes.

374.4 (b) The commissioner may charge a fee for voluntary certification of medical laboratories
 374.5 and environmental laboratories, and for environmental and medical laboratory services
 374.6 provided by the department, without complying with paragraph (a) or chapter 14. Fees
 374.7 charged for environment and medical laboratory services provided by the department must
 374.8 be approximately equal to the costs of providing the services.

374.9 (c) The commissioner may develop a schedule of fees for diagnostic evaluations
 374.10 conducted at clinics held by the services for children with disabilities program. All receipts
 374.11 generated by the program are annually appropriated to the commissioner for use in the
 374.12 maternal and child health program.

374.13 (d) The commissioner shall set license fees for hospitals and nursing homes that are not
 374.14 boarding care homes at the following levels:

374.15	Joint Commission on Accreditation of	\$7,655 plus \$16 per bed
374.16	Healthcare Organizations (JCAHO) and	
374.17	American Osteopathic Association (AOA)	
374.18	hospitals	
374.19	Non-JCAHO and non-AOA hospitals	\$5,280 plus \$250 per bed
374.20	Nursing home	\$183 plus \$91 per bed

374.21 The commissioner shall set license fees for outpatient surgical centers, boarding care
 374.22 homes, and supervised living facilities at the following levels:

374.23	Outpatient surgical centers	\$3,712
374.24	Boarding care homes	\$183 plus \$91 per bed
374.25	Supervised living facilities	\$183 plus \$91 per bed.

374.26 Fees collected under this paragraph are nonrefundable. The fees are nonrefundable even if
 374.27 received before July 1, 2017, for licenses or registrations being issued effective July 1, 2017,
 374.28 or later.

374.29 (e) Unless prohibited by federal law, the commissioner of health shall charge applicants
 374.30 the following fees to cover the cost of any initial certification surveys required to determine
 374.31 a provider's eligibility to participate in the Medicare or Medicaid program:

374.32	Prospective payment surveys for hospitals	\$	900
374.33	Swing bed surveys for nursing homes	\$	1,200
374.34	Psychiatric hospitals	\$	1,400
374.35	Rural health facilities	\$	1,100

375.1	Portable x-ray providers	\$	500
375.2	Home health agencies	\$	1,800
375.3	Outpatient therapy agencies	\$	800
375.4	End stage renal dialysis providers	\$	2,100
375.5	Independent therapists	\$	800
375.6	Comprehensive rehabilitation outpatient facilities	\$	1,200
375.7	Hospice providers	\$	1,700
375.8	Ambulatory surgical providers	\$	1,800
375.9	Hospitals	\$	4,200
375.10	Other provider categories or additional		
375.11	resurveys required to complete initial		
375.12	certification		

Actual surveyor costs: average surveyor cost x number of hours for the survey process.

375.13 These fees shall be submitted at the time of the application for federal certification and
 375.14 shall not be refunded. All fees collected after the date that the imposition of fees is not
 375.15 prohibited by federal law shall be deposited in the state treasury and credited to the state
 375.16 government special revenue fund.

375.17 Sec. 22. Minnesota Statutes 2016, section 144.1501, subdivision 2, is amended to read:

375.18 Subd. 2. **Creation of account.** (a) A health professional education loan forgiveness
 375.19 program account is established. The commissioner of health shall use money from the
 375.20 account to establish a loan forgiveness program:

375.21 (1) for medical residents and mental health professionals agreeing to practice in designated
 375.22 rural areas or underserved urban communities or specializing in the area of pediatric
 375.23 psychiatry;

375.24 (2) for midlevel practitioners agreeing to practice in designated rural areas or to teach
 375.25 at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program
 375.26 at the undergraduate level or the equivalent at the graduate level;

375.27 (3) for nurses who agree to practice in a Minnesota nursing home; an intermediate care
 375.28 facility for persons with developmental disability; ~~or~~ a hospital if the hospital owns and
 375.29 operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by
 375.30 the nurse is in the nursing home; a housing with services establishment as defined in section
 375.31 144D.01, subdivision 4; or for a home care provider as defined in section 144A.43,
 375.32 subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing
 375.33 field in a postsecondary program at the undergraduate level or the equivalent at the graduate
 375.34 level;

376.1 (4) for other health care technicians agreeing to teach at least 12 credit hours, or 720
 376.2 hours per year in their designated field in a postsecondary program at the undergraduate
 376.3 level or the equivalent at the graduate level. The commissioner, in consultation with the
 376.4 Healthcare Education-Industry Partnership, shall determine the health care fields where the
 376.5 need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory
 376.6 technology, radiologic technology, and surgical technology;

376.7 (5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses
 376.8 who agree to practice in designated rural areas; and

376.9 (6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient
 376.10 encounters to state public program enrollees or patients receiving sliding fee schedule
 376.11 discounts through a formal sliding fee schedule meeting the standards established by the
 376.12 United States Department of Health and Human Services under Code of Federal Regulations,
 376.13 title 42, section 51, chapter 303.

376.14 (b) Appropriations made to the account do not cancel and are available until expended,
 376.15 except that at the end of each biennium, any remaining balance in the account that is not
 376.16 committed by contract and not needed to fulfill existing commitments shall cancel to the
 376.17 fund.

376.18 Sec. 23. **[144.1504] SENIOR CARE WORKFORCE INNOVATION GRANT**
 376.19 **PROGRAM.**

376.20 Subdivision 1. Establishment. The senior care workforce innovation grant program is
 376.21 established to assist eligible applicants to fund pilot programs or expand existing programs
 376.22 that increase the pool of caregivers working in the field of senior care services.

376.23 Subd. 2. Competitive grants. The commissioner shall make competitive grants available
 376.24 to eligible applicants to expand the workforce for senior care services.

376.25 Subd. 3. Eligibility. (a) Eligible applicants must recruit and train individuals to work
 376.26 with individuals who are primarily 65 years of age or older and receiving services through:

376.27 (1) a home and community-based setting, including housing with services establishments
 376.28 as defined in section 144D.01, subdivision 4;

376.29 (2) adult day care as defined in section 245A.02, subdivision 2a;

376.30 (3) home care services as defined in section 144A.43, subdivision 3; or

376.31 (4) a nursing home as defined in section 144A.01, subdivision 5.

377.1 (b) Applicants must apply for a senior care workforce innovation grant as specified in
377.2 subdivision 4.

377.3 Subd. 4. **Application.** (a) Eligible applicants must apply for a grant on the forms and
377.4 according to the timelines established by the commissioner.

377.5 (b) Each applicant must propose a project or initiative to expand the number of workers
377.6 in the field of senior care services. At a minimum, a proposal must include:

377.7 (1) a description of the senior care workforce innovation project or initiative being
377.8 proposed, including the process by which the applicant will expand the senior care workforce;

377.9 (2) whether the applicant is proposing to target the proposed project or initiative to any
377.10 of the groups described in paragraph (c);

377.11 (3) information describing the applicant's current senior care workforce project or
377.12 initiative, if applicable;

377.13 (4) the amount of funding the applicant is seeking through the grant program;

377.14 (5) any other sources of funding the applicant has for the project or initiative;

377.15 (6) a proposed budget detailing how the grant funds will be spent; and

377.16 (7) outcomes established by the applicant to measure the success of the project or
377.17 initiative.

377.18 Subd. 5. **Commissioner's duties; requests for proposals; grantee selections.** (a) By
377.19 September 1, 2017, and annually thereafter, the commissioner shall publish a request for
377.20 proposals in the State Register specifying applicant eligibility requirements, qualifying
377.21 senior care workforce innovation program criteria, applicant selection criteria, documentation
377.22 required for program participation, maximum award amount, and methods of evaluation.

377.23 (b) Priority must be given to proposals that target employment of individuals who have
377.24 multiple barriers to employment, individuals who have been unemployed long-term, and
377.25 veterans.

377.26 (c) The commissioner shall determine the maximum award for grants and make grant
377.27 selections based on the information provided in the grant application, including the targeted
377.28 employment population, the applicant's proposed budget, the proposed measurable outcomes,
377.29 and other criteria as determined by the commissioner.

377.30 Subd. 6. **Grant funding.** Notwithstanding any law or rule to the contrary, funds awarded
377.31 to grantees in a grant agreement under this section do not lapse until the grant agreement
377.32 expires.

378.1 Subd. 7. Reporting requirements. (a) Grant recipients shall report to the commissioner
378.2 on the forms and according to the timelines established by the commissioner.

378.3 (b) The commissioner shall report to the chairs and ranking minority members of the
378.4 house of representatives and senate committees with jurisdiction over health by January 15,
378.5 2019, and annually thereafter, on the grant program. The report must include:

378.6 (1) information on each grant recipient;

378.7 (2) a summary of all projects or initiatives undertaken with each grant;

378.8 (3) the measurable outcomes established by each grantee, an explanation of the evaluation
378.9 process used to determine whether the outcomes were met, and the results of the evaluation;
378.10 and

378.11 (4) an accounting of how the grant funds were spent.

378.12 (c) During the grant period, the commissioner may require and collect from grant
378.13 recipients additional information necessary to evaluate the grant program.

378.14 Sec. 24. [144.1505] HEALTH PROFESSIONALS CLINICAL TRAINING
378.15 EXPANSION GRANT PROGRAM.

378.16 Subdivision 1. Definitions. For purposes of this section, the following definitions apply:

378.17 (1) "eligible advanced practice registered nurse program" means a program that is located
378.18 in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level
378.19 advanced practice registered nurse program by the Commission on Collegiate Nursing
378.20 Education or by the Accreditation Commission for Education in Nursing, or is a candidate
378.21 for accreditation;

378.22 (2) "eligible dental therapy program" means a dental therapy education program or
378.23 advanced dental therapy education program that is located in Minnesota and is either:

378.24 (i) approved by the Board of Dentistry; or

378.25 (ii) currently accredited by the Commission on Dental Accreditation;

378.26 (3) "eligible mental health professional program" means a program that is located in
378.27 Minnesota and is listed as a mental health professional program by the appropriate accrediting
378.28 body for clinical social work, psychology, marriage and family therapy, or licensed
378.29 professional clinical counseling, or is a candidate for accreditation;

379.1 (4) "eligible pharmacy program" means a program that is located in Minnesota and is
379.2 currently accredited as a doctor of pharmacy program by the Accreditation Council on
379.3 Pharmacy Education;

379.4 (5) "eligible physician assistant program" means a program that is located in Minnesota
379.5 and is currently accredited as a physician assistant program by the Accreditation Review
379.6 Commission on Education for the Physician Assistant, or is a candidate for accreditation;

379.7 (6) "mental health professional" means an individual providing clinical services in the
379.8 treatment of mental illness who meets one of the qualifications under section 245.462,
379.9 subdivision 18; and

379.10 (7) "project" means a project to establish or expand clinical training for physician
379.11 assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced
379.12 dental therapists, or mental health professionals in Minnesota.

379.13 Subd. 2. **Program.** (a) The commissioner of health shall award health professional
379.14 training site grants to eligible physician assistant, advanced practice registered nurse,
379.15 pharmacy, dental therapy, and mental health professional programs to plan and implement
379.16 expanded clinical training. A planning grant shall not exceed \$75,000, and a training grant
379.17 shall not exceed \$150,000 for the first year, \$100,000 for the second year, and \$50,000 for
379.18 the third year per program.

379.19 (b) Funds may be used for:

379.20 (1) establishing or expanding clinical training for physician assistants, advanced practice
379.21 registered nurses, pharmacists, dental therapists, advanced dental therapists, and mental
379.22 health professionals in Minnesota;

379.23 (2) recruitment, training, and retention of students and faculty;

379.24 (3) connecting students with appropriate clinical training sites, internships, practicums,
379.25 or externship activities;

379.26 (4) travel and lodging for students;

379.27 (5) faculty, student, and preceptor salaries, incentives, or other financial support;

379.28 (6) development and implementation of cultural competency training;

379.29 (7) evaluations;

379.30 (8) training site improvements, fees, equipment, and supplies required to establish,
379.31 maintain, or expand a physician assistant, advanced practice registered nurse, pharmacy,
379.32 dental therapy, or mental health professional training program; and

380.1 (9) supporting clinical education in which trainees are part of a primary care team model.

380.2 Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse,
 380.3 pharmacy, dental therapy, and mental health professional programs seeking a grant shall
 380.4 apply to the commissioner. Applications must include a description of the number of
 380.5 additional students who will be trained using grant funds; attestation that funding will be
 380.6 used to support an increase in the number of clinical training slots; a description of the
 380.7 problem that the proposed project will address; a description of the project, including all
 380.8 costs associated with the project, sources of funds for the project, detailed uses of all funds
 380.9 for the project, and the results expected; and a plan to maintain or operate any component
 380.10 included in the project after the grant period. The applicant must describe achievable
 380.11 objectives, a timetable, and roles and capabilities of responsible individuals in the
 380.12 organization.

380.13 Subd. 4. **Consideration of applications.** The commissioner shall review each application
 380.14 to determine whether or not the application is complete and whether the program and the
 380.15 project are eligible for a grant. In evaluating applications, the commissioner shall score each
 380.16 application based on factors including, but not limited to, the applicant's clarity and
 380.17 thoroughness in describing the project and the problems to be addressed, the extent to which
 380.18 the applicant has demonstrated that the applicant has made adequate provisions to ensure
 380.19 proper and efficient operation of the training program once the grant project is completed,
 380.20 the extent to which the proposed project is consistent with the goal of increasing access to
 380.21 primary care and mental health services for rural and underserved urban communities, the
 380.22 extent to which the proposed project incorporates team-based primary care, and project
 380.23 costs and use of funds.

380.24 Subd. 5. **Program oversight.** The commissioner shall determine the amount of a grant
 380.25 to be given to an eligible program based on the relative score of each eligible program's
 380.26 application, other relevant factors discussed during the review, and the funds available to
 380.27 the commissioner. Appropriations made to the program do not cancel and are available until
 380.28 expended. During the grant period, the commissioner may require and collect from programs
 380.29 receiving grants any information necessary to evaluate the program.

380.30 Sec. 25. Minnesota Statutes 2016, section 144.1506, is amended to read:

380.31 **144.1506 ~~PRIMARY CARE~~ PHYSICIAN RESIDENCY EXPANSION GRANT**
 380.32 **PROGRAM.**

380.33 Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

381.1 (1) "eligible ~~primary-care~~ physician residency program" means a program that meets
381.2 the following criteria:

381.3 (i) is located in Minnesota;

381.4 (ii) trains medical residents in the specialties of family medicine, general internal
381.5 medicine, general pediatrics, psychiatry, geriatrics, ~~or~~ general surgery, obstetrics and
381.6 gynecology, or other physician specialties with training programs that incorporate rural
381.7 training components; and

381.8 (iii) is accredited by the Accreditation Council for Graduate Medical Education or
381.9 presents a credible plan to obtain accreditation;

381.10 (2) "eligible project" means a project to establish a new eligible ~~primary-care~~ physician
381.11 residency program or create at least one new residency slot in an existing eligible ~~primary~~
381.12 ~~care~~ physician residency program; and

381.13 (3) "new residency slot" means the creation of a new residency position and the execution
381.14 of a contract with a new resident in a residency program.

381.15 Subd. 2. **Expansion grant program.** (a) The commissioner of health shall award ~~primary~~
381.16 ~~care~~ physician residency expansion grants to eligible ~~primary-care~~ physician residency
381.17 programs to plan and implement new residency slots. A planning grant shall not exceed
381.18 \$75,000, and a training grant shall not exceed \$150,000 per new residency slot for the first
381.19 year, \$100,000 for the second year, and \$50,000 for the third year of the new residency slot.

381.20 (b) Funds may be spent to cover the costs of:

381.21 (1) planning related to establishing an accredited ~~primary-care~~ physician residency
381.22 program;

381.23 (2) obtaining accreditation by the Accreditation Council for Graduate Medical Education
381.24 or another national body that accredits residency programs;

381.25 (3) establishing new residency programs or new resident training slots;

381.26 (4) recruitment, training, and retention of new residents and faculty;

381.27 (5) travel and lodging for new residents;

381.28 (6) faculty, new resident, and preceptor salaries related to new residency slots;

381.29 (7) training site improvements, fees, equipment, and supplies required for new ~~primary~~
381.30 ~~care~~ physician resident training slots; and

381.31 (8) supporting clinical education in which trainees are part of a primary care team model.

382.1 Subd. 3. **Applications for expansion grants.** Eligible ~~primary care~~ physician residency
382.2 programs seeking a grant shall apply to the commissioner. Applications must include the
382.3 number of new ~~primary care~~ physician residency slots planned or under contract; attestation
382.4 that funding will be used to support an increase in the number of available residency slots;
382.5 a description of the training to be received by the new residents, including the location of
382.6 training; a description of the project, including all costs associated with the project; all
382.7 sources of funds for the project; detailed uses of all funds for the project; the results expected;
382.8 and a plan to maintain the new residency slot after the grant period. The applicant must
382.9 describe achievable objectives, a timetable, and roles and capabilities of responsible
382.10 individuals in the organization.

382.11 Subd. 4. **Consideration of expansion grant applications.** The commissioner shall
382.12 review each application to determine whether or not the residency program application is
382.13 complete and whether the proposed new residency program and any new residency slots
382.14 are eligible for a grant. The commissioner shall award grants to support up to six family
382.15 medicine, general internal medicine, or general pediatrics residents; four psychiatry residents;
382.16 two geriatrics residents; ~~and two~~ four general surgery residents; two obstetrics and
382.17 gynecology residents; and four specialty physician residents participating in training programs
382.18 that incorporate rural training components. If insufficient applications are received from
382.19 any eligible specialty, funds may be redistributed to applications from other eligible
382.20 specialties.

382.21 Subd. 5. **Program oversight.** During the grant period, the commissioner may require
382.22 and collect from grantees any information necessary to evaluate the program. Appropriations
382.23 made to the program do not cancel and are available until expended.

382.24 Sec. 26. [144.397] STATEWIDE TOBACCO QUITLINE SERVICES.

382.25 (a) The commissioner of health shall administer, or contract for the administration of,
382.26 a statewide tobacco quitline service to assist Minnesotans who are seeking advice or services
382.27 to help them quit using tobacco products. The commissioner shall establish statewide public
382.28 awareness activities to inform the public of the availability of the service and encourage
382.29 the public to utilize the services because of the dangers and harm of tobacco use and
382.30 dependence.

382.31 (b) Services to be provided include, but are not limited to:

382.32 (1) telephone-based coaching and counseling;

382.33 (2) referrals;

383.1 (3) written materials mailed upon request;

383.2 (4) Web-based texting or e-mail services; and

383.3 (5) free Food and Drug Administration-approved tobacco cessation medications.

383.4 (c) Services provided must be consistent with evidence-based best practices in tobacco
383.5 cessation services. Services provided must be coordinated with employer, health plan
383.6 company, and private sector tobacco prevention and cessation services that may be available
383.7 to individuals depending on their employment or health coverage.

383.8 Sec. 27. Minnesota Statutes 2016, section 144.551, subdivision 1, is amended to read:

383.9 Subdivision 1. **Restricted construction or modification.** (a) The following construction
383.10 or modification may not be commenced:

383.11 (1) any erection, building, alteration, reconstruction, modernization, improvement,
383.12 extension, lease, or other acquisition by or on behalf of a hospital that increases the bed
383.13 capacity of a hospital, relocates hospital beds from one physical facility, complex, or site
383.14 to another, or otherwise results in an increase or redistribution of hospital beds within the
383.15 state; and

383.16 (2) the establishment of a new hospital.

383.17 (b) This section does not apply to:

383.18 (1) construction or relocation within a county by a hospital, clinic, or other health care
383.19 facility that is a national referral center engaged in substantial programs of patient care,
383.20 medical research, and medical education meeting state and national needs that receives more
383.21 than 40 percent of its patients from outside the state of Minnesota;

383.22 (2) a project for construction or modification for which a health care facility held an
383.23 approved certificate of need on May 1, 1984, regardless of the date of expiration of the
383.24 certificate;

383.25 (3) a project for which a certificate of need was denied before July 1, 1990, if a timely
383.26 appeal results in an order reversing the denial;

383.27 (4) a project exempted from certificate of need requirements by Laws 1981, chapter 200,
383.28 section 2;

383.29 (5) a project involving consolidation of pediatric specialty hospital services within the
383.30 Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number
383.31 of pediatric specialty hospital beds among the hospitals being consolidated;

384.1 (6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to
384.2 an existing licensed hospital that will allow for the reconstruction of a new philanthropic,
384.3 pediatric-orthopedic hospital on an existing site and that will not result in a net increase in
384.4 the number of hospital beds. Upon completion of the reconstruction, the licenses of both
384.5 hospitals must be reinstated at the capacity that existed on each site before the relocation;

384.6 (7) the relocation or redistribution of hospital beds within a hospital building or
384.7 identifiable complex of buildings provided the relocation or redistribution does not result
384.8 in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from
384.9 one physical site or complex to another; or (iii) redistribution of hospital beds within the
384.10 state or a region of the state;

384.11 (8) relocation or redistribution of hospital beds within a hospital corporate system that
384.12 involves the transfer of beds from a closed facility site or complex to an existing site or
384.13 complex provided that: (i) no more than 50 percent of the capacity of the closed facility is
384.14 transferred; (ii) the capacity of the site or complex to which the beds are transferred does
384.15 not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal
384.16 health systems agency boundary in place on July 1, 1983; and (iv) the relocation or
384.17 redistribution does not involve the construction of a new hospital building;

384.18 (9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice
384.19 County that primarily serves adolescents and that receives more than 70 percent of its
384.20 patients from outside the state of Minnesota;

384.21 (10) a project to replace a hospital or hospitals with a combined licensed capacity of
384.22 130 beds or less if: (i) the new hospital site is located within five miles of the current site;
384.23 and (ii) the total licensed capacity of the replacement hospital, either at the time of
384.24 construction of the initial building or as the result of future expansion, will not exceed 70
384.25 licensed hospital beds, or the combined licensed capacity of the hospitals, whichever is less;

384.26 (11) the relocation of licensed hospital beds from an existing state facility operated by
384.27 the commissioner of human services to a new or existing facility, building, or complex
384.28 operated by the commissioner of human services; from one regional treatment center site
384.29 to another; or from one building or site to a new or existing building or site on the same
384.30 campus;

384.31 (12) the construction or relocation of hospital beds operated by a hospital having a
384.32 statutory obligation to provide hospital and medical services for the indigent that does not
384.33 result in a net increase in the number of hospital beds, notwithstanding section 144.552, 27

385.1 beds, of which 12 serve mental health needs, may be transferred from Hennepin County
385.2 Medical Center to Regions Hospital under this clause;

385.3 (13) a construction project involving the addition of up to 31 new beds in an existing
385.4 nonfederal hospital in Beltrami County;

385.5 (14) a construction project involving the addition of up to eight new beds in an existing
385.6 nonfederal hospital in Otter Tail County with 100 licensed acute care beds;

385.7 (15) a construction project involving the addition of 20 new hospital beds used for
385.8 rehabilitation services in an existing hospital in Carver County serving the southwest
385.9 suburban metropolitan area. Beds constructed under this clause shall not be eligible for
385.10 reimbursement under medical assistance or MinnesotaCare;

385.11 (16) a project for the construction or relocation of up to 20 hospital beds for the operation
385.12 of up to two psychiatric facilities or units for children provided that the operation of the
385.13 facilities or units have received the approval of the commissioner of human services;

385.14 (17) a project involving the addition of 14 new hospital beds to be used for rehabilitation
385.15 services in an existing hospital in Itasca County;

385.16 (18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County
385.17 that closed 20 rehabilitation beds in 2002, provided that the beds are used only for
385.18 rehabilitation in the hospital's current rehabilitation building. If the beds are used for another
385.19 purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds;

385.20 (19) a critical access hospital established under section 144.1483, clause (9), and section
385.21 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that
385.22 delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33,
385.23 to the extent that the critical access hospital does not seek to exceed the maximum number
385.24 of beds permitted such hospital under federal law;

385.25 (20) notwithstanding section 144.552, a project for the construction of a new hospital
385.26 in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

385.27 (i) the project, including each hospital or health system that will own or control the entity
385.28 that will hold the new hospital license, is approved by a resolution of the Maple Grove City
385.29 Council as of March 1, 2006;

385.30 (ii) the entity that will hold the new hospital license will be owned or controlled by one
385.31 or more not-for-profit hospitals or health systems that have previously submitted a plan or
385.32 plans for a project in Maple Grove as required under section 144.552, and the plan or plans

386.1 have been found to be in the public interest by the commissioner of health as of April 1,
386.2 2005;

386.3 (iii) the new hospital's initial inpatient services must include, but are not limited to,
386.4 medical and surgical services, obstetrical and gynecological services, intensive care services,
386.5 orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health
386.6 services, and emergency room services;

386.7 (iv) the new hospital:

386.8 (A) will have the ability to provide and staff sufficient new beds to meet the growing
386.9 needs of the Maple Grove service area and the surrounding communities currently being
386.10 served by the hospital or health system that will own or control the entity that will hold the
386.11 new hospital license;

386.12 (B) will provide uncompensated care;

386.13 (C) will provide mental health services, including inpatient beds;

386.14 (D) will be a site for workforce development for a broad spectrum of health-care-related
386.15 occupations and have a commitment to providing clinical training programs for physicians
386.16 and other health care providers;

386.17 (E) will demonstrate a commitment to quality care and patient safety;

386.18 (F) will have an electronic medical records system, including physician order entry;

386.19 (G) will provide a broad range of senior services;

386.20 (H) will provide emergency medical services that will coordinate care with regional
386.21 providers of trauma services and licensed emergency ambulance services in order to enhance
386.22 the continuity of care for emergency medical patients; and

386.23 (I) will be completed by December 31, 2009, unless delayed by circumstances beyond
386.24 the control of the entity holding the new hospital license; and

386.25 (v) as of 30 days following submission of a written plan, the commissioner of health
386.26 has not determined that the hospitals or health systems that will own or control the entity
386.27 that will hold the new hospital license are unable to meet the criteria of this clause;

386.28 (21) a project approved under section 144.553;

386.29 (22) a project for the construction of a hospital with up to 25 beds in Cass County within
386.30 a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder
386.31 is approved by the Cass County Board;

387.1 (23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity
387.2 from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing
387.3 a separately licensed 13-bed skilled nursing facility;

387.4 (24) notwithstanding section 144.552, a project for the construction and expansion of a
387.5 specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients
387.6 who are under 21 years of age on the date of admission. The commissioner conducted a
387.7 public interest review of the mental health needs of Minnesota and the Twin Cities
387.8 metropolitan area in 2008. No further public interest review shall be conducted for the
387.9 construction or expansion project under this clause;

387.10 (25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the
387.11 commissioner finds the project is in the public interest after the public interest review
387.12 conducted under section 144.552 is complete; ~~or~~

387.13 (26)(i) a project for a 20-bed psychiatric hospital, within an existing facility in the city
387.14 of Maple Grove, exclusively for patients who are under 21 years of age on the date of
387.15 admission, if the commissioner finds the project is in the public interest after the public
387.16 interest review conducted under section 144.552 is complete;

387.17 (ii) this project shall serve patients in the continuing care benefit program under section
387.18 256.9693. The project may also serve patients not in the continuing care benefit program;
387.19 and

387.20 (iii) if the project ceases to participate in the continuing care benefit program, the
387.21 commissioner must complete a subsequent public interest review under section 144.552. If
387.22 the project is found not to be in the public interest, the license must be terminated six months
387.23 from the date of that finding. If the commissioner of human services terminates the contract
387.24 without cause or reduces per diem payment rates for patients under the continuing care
387.25 benefit program below the rates in effect for services provided on December 31, 2015, the
387.26 project may cease to participate in the continuing care benefit program and continue to
387.27 operate without a subsequent public interest review; or

387.28 (27) a project involving the addition of 21 new beds in an existing psychiatric hospital
387.29 in Hennepin County that is exclusively for patients who are under 21 years of age on the
387.30 date of admission.

387.31 **EFFECTIVE DATE.** This section is effective the day following final enactment.

388.1 Sec. 28. [144.88] MINNESOTA BIOMEDICINE AND BIOETHICS INNOVATION
388.2 GRANTS.

388.3 Subdivision 1. Grants. (a) The commissioner of health, in consultation with interested
388.4 parties with relevant knowledge and expertise as specified in subdivision 2, shall award
388.5 grants to entities that apply for a grant under this subdivision to fund innovations and research
388.6 in biomedicine and bioethics. Grant funds must be used to fund biomedical and bioethical
388.7 research, and related clinical translation and commercialization activities in this state. Entities
388.8 applying for a grant must do so in a form and manner specified by the commissioner. The
388.9 commissioner and interested parties shall use the following criteria to award grants under
388.10 this subdivision:

388.11 (1) the likelihood that the research will lead to a new discovery;

388.12 (2) the prospects for commercialization of the research;

388.13 (3) the likelihood that the research will strengthen Minnesota's economy through the
388.14 creation of new businesses, increased public or private funding for research in Minnesota,
388.15 or attracting additional clinicians and researchers to Minnesota; and

388.16 (4) whether the proposed research includes a bioethics research plan to ensure the research
388.17 is conducted using ethical research practices.

388.18 (b) Projects that include the acquisition or use of human fetal tissue are not eligible for
388.19 grants under this subdivision. For purposes of this paragraph, "human fetal tissue" has the
388.20 meaning given in United States Code, title 42, section 289g-1(f).

388.21 Subd. 2. Consultation. In awarding grants under subdivision 1, the commissioner must
388.22 consult with interested parties who are able to provide the commissioner with technical
388.23 information, advice, and recommendations on grant projects and awards. Interested parties
388.24 with whom the commissioner must consult include but are not limited to representatives of
388.25 the University of Minnesota, Mayo Clinic, and private industries who have expertise in
388.26 biomedical research, bioethical research, clinical translation, commercialization, and medical
388.27 venture financing.

388.28 Sec. 29. Minnesota Statutes 2016, section 144.99, subdivision 1, is amended to read:

388.29 Subdivision 1. Remedies available. The provisions of chapters 103I and 157 and sections
388.30 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14),
388.31 and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385;
388.32 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98;
388.33 144.992; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders,

389.1 stipulation agreements, settlements, compliance agreements, licenses, registrations,
 389.2 certificates, and permits adopted or issued by the department or under any other law now
 389.3 in force or later enacted for the preservation of public health may, in addition to provisions
 389.4 in other statutes, be enforced under this section.

389.5 Sec. 30. Minnesota Statutes 2016, section 144A.472, subdivision 7, is amended to read:

389.6 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant
 389.7 seeking temporary home care licensure must submit the following application fee to the
 389.8 commissioner along with a completed application:

389.9 (1) for a basic home care provider, \$2,100; or

389.10 (2) for a comprehensive home care provider, \$4,200.

389.11 (b) A home care provider who is filing a change of ownership as required under
 389.12 subdivision 5 must submit the following application fee to the commissioner, along with
 389.13 the documentation required for the change of ownership:

389.14 (1) for a basic home care provider, \$2,100; or

389.15 (2) for a comprehensive home care provider, \$4,200.

389.16 (c) A home care provider who is seeking to renew the provider's license shall pay a fee
 389.17 to the commissioner based on revenues derived from the provision of home care services
 389.18 during the calendar year prior to the year in which the application is submitted, according
 389.19 to the following schedule:

389.20 License Renewal Fee

389.21 Provider Annual Revenue	Fee
389.22 greater than \$1,500,000	\$6,625
389.23 greater than \$1,275,000 and no more than 389.24 \$1,500,000	\$5,797
389.25 greater than \$1,100,000 and no more than 389.26 \$1,275,000	\$4,969
389.27 greater than \$950,000 and no more than 389.28 \$1,100,000	\$4,141
389.29 greater than \$850,000 and no more than \$950,000	\$3,727
389.30 greater than \$750,000 and no more than \$850,000	\$3,313
389.31 greater than \$650,000 and no more than \$750,000	\$2,898
389.32 greater than \$550,000 and no more than \$650,000	\$2,485
389.33 greater than \$450,000 and no more than \$550,000	\$2,070
389.34 greater than \$350,000 and no more than \$450,000	\$1,656

390.1	greater than \$250,000 and no more than \$350,000	\$1,242
390.2	greater than \$100,000 and no more than \$250,000	\$828
390.3	greater than \$50,000 and no more than \$100,000	\$500
390.4	greater than \$25,000 and no more than \$50,000	\$400
390.5	no more than \$25,000	\$200

390.6 (d) If requested, the home care provider shall provide the commissioner information to
 390.7 verify the provider's annual revenues or other information as needed, including copies of
 390.8 documents submitted to the Department of Revenue.

390.9 (e) At each annual renewal, a home care provider may elect to pay the highest renewal
 390.10 fee for its license category, and not provide annual revenue information to the commissioner.

390.11 (f) A temporary license or license applicant, or temporary licensee or licensee that
 390.12 knowingly provides the commissioner incorrect revenue amounts for the purpose of paying
 390.13 a lower license fee, shall be subject to a civil penalty in the amount of double the fee the
 390.14 provider should have paid.

390.15 (g) Fees and penalties collected under this section shall be deposited in the state treasury
 390.16 and credited to the state government special revenue fund. All fees are nonrefundable. Fees
 390.17 collected under paragraph (c) are nonrefundable even if received before July 1, 2017, for
 390.18 temporary licenses or licenses being issued effective July 1, 2017, or later.

390.19 (h) The license renewal fee schedule in this subdivision is effective July 1, 2016.

390.20 Sec. 31. Minnesota Statutes 2016, section 144A.474, subdivision 11, is amended to read:

390.21 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed
 390.22 based on the level and scope of the violations described in paragraph (c) as follows:

390.23 (1) Level 1, no fines or enforcement;

390.24 (2) Level 2, fines ranging from \$0 to \$500, in addition to any of the enforcement
 390.25 mechanisms authorized in section 144A.475 for widespread violations;

390.26 (3) Level 3, fines ranging from \$500 to \$1,000, in addition to any of the enforcement
 390.27 mechanisms authorized in section 144A.475; and

390.28 (4) Level 4, fines ranging from \$1,000 to \$5,000, in addition to any of the enforcement
 390.29 mechanisms authorized in section 144A.475.

390.30 (b) Correction orders for violations are categorized by both level and scope and fines
 390.31 shall be assessed as follows:

391.1 (1) level of violation:

391.2 (i) Level 1 is a violation that has no potential to cause more than a minimal impact on
391.3 the client and does not affect health or safety;

391.4 (ii) Level 2 is a violation that did not harm a client's health or safety but had the potential
391.5 to have harmed a client's health or safety, but was not likely to cause serious injury,
391.6 impairment, or death;

391.7 (iii) Level 3 is a violation that harmed a client's health or safety, not including serious
391.8 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
391.9 impairment, or death; and

391.10 (iv) Level 4 is a violation that results in serious injury, impairment, or death.

391.11 (2) scope of violation:

391.12 (i) isolated, when one or a limited number of clients are affected or one or a limited
391.13 number of staff are involved or the situation has occurred only occasionally;

391.14 (ii) pattern, when more than a limited number of clients are affected, more than a limited
391.15 number of staff are involved, or the situation has occurred repeatedly but is not found to be
391.16 pervasive; and

391.17 (iii) widespread, when problems are pervasive or represent a systemic failure that has
391.18 affected or has the potential to affect a large portion or all of the clients.

391.19 (c) If the commissioner finds that the applicant or a home care provider required to be
391.20 licensed under sections 144A.43 to 144A.482 has not corrected violations by the date
391.21 specified in the correction order or conditional license resulting from a survey or complaint
391.22 investigation, the commissioner may impose a fine. A notice of noncompliance with a
391.23 correction order must be mailed to the applicant's or provider's last known address. The
391.24 noncompliance notice must list the violations not corrected.

391.25 (d) The license holder must pay the fines assessed on or before the payment date specified.
391.26 If the license holder fails to fully comply with the order, the commissioner may issue a
391.27 second fine or suspend the license until the license holder complies by paying the fine. A
391.28 timely appeal shall stay payment of the fine until the commissioner issues a final order.

391.29 (e) A license holder shall promptly notify the commissioner in writing when a violation
391.30 specified in the order is corrected. If upon reinspection the commissioner determines that
391.31 a violation has not been corrected as indicated by the order, the commissioner may issue a
391.32 second fine. The commissioner shall notify the license holder by mail to the last known

392.1 address in the licensing record that a second fine has been assessed. The license holder may
392.2 appeal the second fine as provided under this subdivision.

392.3 (f) A home care provider that has been assessed a fine under this subdivision has a right
392.4 to a reconsideration or a hearing under this section and chapter 14.

392.5 (g) When a fine has been assessed, the license holder may not avoid payment by closing,
392.6 selling, or otherwise transferring the licensed program to a third party. In such an event, the
392.7 license holder shall be liable for payment of the fine.

392.8 (h) In addition to any fine imposed under this section, the commissioner may assess
392.9 costs related to an investigation that results in a final order assessing a fine or other
392.10 enforcement action authorized by this chapter.

392.11 (i) Fines collected under this subdivision shall be deposited in the state government
392.12 special revenue fund and credited to an account separate from the revenue collected under
392.13 section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines
392.14 collected ~~may~~ must be used by the commissioner for special projects to improve home care
392.15 in Minnesota as recommended by the advisory council established in section 144A.4799.

392.16 Sec. 32. Minnesota Statutes 2016, section 144A.4799, subdivision 3, is amended to read:

392.17 Subd. 3. **Duties.** (a) At the commissioner's request, the advisory council shall provide
392.18 advice regarding regulations of Department of Health licensed home care providers in this
392.19 chapter, including advice on the following:

392.20 (1) community standards for home care practices;

392.21 (2) enforcement of licensing standards and whether certain disciplinary actions are
392.22 appropriate;

392.23 (3) ways of distributing information to licensees and consumers of home care;

392.24 (4) training standards;

392.25 (5) identifying emerging issues and opportunities in the home care field, including the
392.26 use of technology in home and telehealth capabilities;

392.27 (6) allowable home care licensing modifications and exemptions, including a method
392.28 for an integrated license with an existing license for rural licensed nursing homes to provide
392.29 limited home care services in an adjacent independent living apartment building owned by
392.30 the licensed nursing home; and

393.1 (7) recommendations for studies using the data in section 62U.04, subdivision 4, including
 393.2 but not limited to studies concerning costs related to dementia and chronic disease among
 393.3 an elderly population over 60 and additional long-term care costs, as described in section
 393.4 62U.10, subdivision 6.

393.5 (b) The advisory council shall perform other duties as directed by the commissioner.

393.6 (c) The advisory council shall annually review the balance of the account in the state
 393.7 government special revenue fund described in section 144A.474, subdivision 11, paragraph
 393.8 (i), and make annual recommendations by January 15 directly to the chairs and ranking
 393.9 minority members of the legislative committees with jurisdiction over health and human
 393.10 services regarding appropriations to the commissioner for the purposes in section 144A.474,
 393.11 subdivision 11, paragraph (i).

393.12 Sec. 33. Minnesota Statutes 2016, section 144A.70, is amended by adding a subdivision
 393.13 to read:

393.14 Subd. 4a. **Nurse.** "Nurse" means a licensed practical nurse as defined in section 148.171,
 393.15 subdivision 8, or a registered nurse as defined in section 148.171, subdivision 20.

393.16 **EFFECTIVE DATE.** This section is effective the day following final enactment.

393.17 Sec. 34. Minnesota Statutes 2016, section 144A.70, subdivision 6, is amended to read:

393.18 Subd. 6. **Supplemental nursing services agency.** "Supplemental nursing services
 393.19 agency" means a person, firm, corporation, partnership, or association engaged for hire in
 393.20 the business of providing or procuring temporary employment in health care facilities for
 393.21 nurses, nursing assistants, nurse aides, and orderlies,~~and other licensed health professionals.~~
 393.22 Supplemental nursing services agency does not include an individual who only engages in
 393.23 providing the individual's services on a temporary basis to health care facilities. Supplemental
 393.24 nursing services agency does not include a professional home care agency licensed under
 393.25 section 144A.471 that only provides staff to other home care providers.

393.26 **EFFECTIVE DATE.** This section is effective the day following final enactment.

393.27 Sec. 35. Minnesota Statutes 2016, section 144D.06, is amended to read:

393.28 **144D.06 OTHER LAWS.**

393.29 In addition to registration under this chapter, a housing with services establishment **must**
 393.30 comply with chapter 504B and the provisions of section 325F.72, and shall obtain and
 393.31 maintain all other licenses, permits, registrations, or other governmental approvals required

394.1 of it ~~in addition to registration under this chapter~~. A housing with services establishment is
394.2 ~~subject to the provisions of section 325F.72 and chapter 504B~~ not required to obtain a
394.3 lodging license under chapter 157 and related rules.

394.4 **EFFECTIVE DATE.** This section is effective August 1, 2017.

394.5 Sec. 36. **[144H.01] DEFINITIONS.**

394.6 Subdivision 1. **Application.** The terms defined in this section apply to this chapter.

394.7 Subd. 2. **Basic services.** "Basic services" includes but is not limited to:

394.8 (1) the development, implementation, and monitoring of a comprehensive protocol of
394.9 care that is developed in conjunction with the parent or guardian of a medically complex
394.10 or technologically dependent child and that specifies the medical, nursing, psychosocial,
394.11 and developmental therapies required by the medically complex or technologically dependent
394.12 child; and

394.13 (2) the caregiver training needs of the child's parent or guardian.

394.14 Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

394.15 Subd. 4. **Licensee.** "Licensee" means an owner of a prescribed pediatric extended care
394.16 (PPEC) center licensed under this chapter.

394.17 Subd. 5. **Medically complex or technologically dependent child.** "Medically complex
394.18 or technologically dependent child" means a child under 21 years of age who, because of
394.19 a medical condition, requires continuous therapeutic interventions or skilled nursing
394.20 supervision which must be prescribed by a licensed physician and administered by, or under
394.21 the direct supervision of, a licensed registered nurse.

394.22 Subd. 6. **Owner.** "Owner" means an individual whose ownership interest provides
394.23 sufficient authority or control to affect or change decisions regarding the operation of the
394.24 PPEC center. An owner includes a sole proprietor, a general partner, or any other individual
394.25 whose ownership interest has the ability to affect the management and direction of the PPEC
394.26 center's policies.

394.27 Subd. 7. **Prescribed pediatric extended care center, PPEC center, or center.**

394.28 "Prescribed pediatric extended care center," "PPEC center," or "center" means any facility
394.29 that provides nonresidential basic services to three or more medically complex or
394.30 technologically dependent children who require such services and who are not related to
394.31 the owner by blood, marriage, or adoption.

395.1 Subd. 8. **Supportive services or contracted services.** "Supportive services or contracted
395.2 services" include but are not limited to speech therapy, occupational therapy, physical
395.3 therapy, social work services, developmental services, child life services, and psychology
395.4 services.

395.5 Sec. 37. [144H.02] LICENSURE REQUIRED.

395.6 A person may not own or operate a prescribed pediatric extended care center in this state
395.7 unless the person holds a temporary or current license issued under this chapter. A separate
395.8 license must be obtained for each PPEC center maintained on separate premises, even if
395.9 the same management operates the PPEC centers. Separate licenses are not required for
395.10 separate buildings on the same grounds. A center shall not be operated on the same grounds
395.11 as a child care center licensed under Minnesota Rules, chapter 9503.

395.12 Sec. 38. [144H.03] EXEMPTIONS.

395.13 This chapter does not apply to:

395.14 (1) a facility operated by the United States government or a federal agency; or

395.15 (2) a health care facility licensed under chapter 144 or 144A.

395.16 Sec. 39. [144H.04] LICENSE APPLICATION AND RENEWAL.

395.17 Subdivision 1. **Licenses.** A person seeking licensure for a PPEC center must submit a
395.18 completed application for licensure to the commissioner, in a form and manner determined
395.19 by the commissioner. The applicant must also submit the application fee, in the amount
395.20 specified in section 144H.05, subdivision 1. Effective January 1, 2018, the commissioner
395.21 shall issue a license for a PPEC center if the commissioner determines that the applicant
395.22 and center meet the requirements of this chapter and rules that apply to PPEC centers. A
395.23 license issued under this subdivision is valid for two years.

395.24 Subd. 2. **License renewal.** A license issued under subdivision 1 may be renewed for a
395.25 period of two years if the licensee:

395.26 (1) submits an application for renewal in a form and manner determined by the
395.27 commissioner, at least 30 days before the license expires. An application for renewal
395.28 submitted after the renewal deadline date must be accompanied by a late fee in the amount
395.29 specified in section 144H.05, subdivision 3;

395.30 (2) submits the renewal fee in the amount specified in section 144H.05, subdivision 2;

396.1 (3) demonstrates that the licensee has provided basic services at the PPEC center within
 396.2 the past two years;

396.3 (4) provides evidence that the applicant meets the requirements for licensure; and

396.4 (5) provides other information required by the commissioner.

396.5 Subd. 3. **License not transferable.** A PPEC center license issued under this section is
 396.6 not transferable to another party. Before acquiring ownership of a PPEC center, a prospective
 396.7 applicant must apply to the commissioner for a new license.

396.8 Sec. 40. **[144H.05] FEES.**

396.9 Subdivision 1. **Initial application fee.** The initial application fee for PPEC center
 396.10 licensure is \$3,820.

396.11 Subd. 2. **License renewal.** The fee for renewal of a PPEC center license is \$1,800.

396.12 Subd. 3. **Late fee.** The fee for late submission of an application to renew a PPEC center
 396.13 license is \$25.

396.14 Subd. 4. **Change of ownership.** The fee for change of ownership of a PPEC center is
 396.15 \$4,200.

396.16 Subd. 5. **Nonrefundable; state government special revenue fund.** All fees collected
 396.17 under this chapter are nonrefundable and must be deposited in the state treasury and credited
 396.18 to the state government special revenue fund.

396.19 Sec. 41. **[144H.06] APPLICATION OF RULES FOR HOSPICE SERVICES AND**
 396.20 **RESIDENTIAL HOSPICE FACILITIES.**

396.21 Minnesota Rules, chapter 4664, shall apply to PPEC centers licensed under this chapter,
 396.22 except that the following parts, subparts, items, and subitems do not apply:

396.23 (1) Minnesota Rules, part 4664.0003, subparts 2, 6, 7, 11, 12, 13, 14, and 38;

396.24 (2) Minnesota Rules, part 4664.0008;

396.25 (3) Minnesota Rules, part 4664.0010, subparts 3; 4, items A, subitem (6), and B; and 8;

396.26 (4) Minnesota Rules, part 4664.0020, subpart 13;

396.27 (5) Minnesota Rules, part 4664.0370, subpart 1;

396.28 (6) Minnesota Rules, part 4664.0390, subpart 1, items A, C, and E;

396.29 (7) Minnesota Rules, part 4664.0420;

397.1 (8) Minnesota Rules, part 4664.0425, subparts 3, item A; 4; and 6;

397.2 (9) Minnesota Rules, part 4664.0430, subparts 3, 4, 5, 7, 8, 9, 10, 11, and 12;

397.3 (10) Minnesota Rules, part 4664.0490; and

397.4 (11) Minnesota Rules, part 4664.0520.

397.5 Sec. 42. **[144H.07] SERVICES; LIMITATIONS.**

397.6 Subdivision 1. **Services.** A PPEC center must provide basic services to medically complex
397.7 or technologically dependent children, based on a protocol of care established for each child.

397.8 A PPEC center may provide services up to 14 hours a day and up to six days a week.

397.9 Subd. 2. **Limitations.** A PPEC center must comply with the following standards related
397.10 to services:

397.11 (1) a child is prohibited from attending a PPEC center for more than 14 hours within a
397.12 24-hour period;

397.13 (2) a PPEC center is prohibited from providing services other than those provided to
397.14 medically complex or technologically dependent children; and

397.15 (3) the maximum capacity for medically complex or technologically dependent children
397.16 at a center shall not exceed 45 children.

397.17 Sec. 43. **[144H.08] ADMINISTRATION AND MANAGEMENT.**

397.18 Subdivision 1. **Duties of owner.** (a) The owner of a PPEC center shall have full legal
397.19 authority and responsibility for the operation of the center. A PPEC center must be organized
397.20 according to a written table of organization, describing the lines of authority and
397.21 communication to the child care level. The organizational structure must be designed to
397.22 ensure an integrated continuum of services for the children served.

397.23 (b) The owner must designate one person as a center administrator, who is responsible
397.24 and accountable for overall management of the center.

397.25 Subd. 2. **Duties of administrator.** The center administrator is responsible and accountable
397.26 for overall management of the center. The administrator must:

397.27 (1) designate in writing a person to be responsible for the center when the administrator
397.28 is absent from the center for more than 24 hours;

397.29 (2) maintain the following written records, in a place and form and using a system that
397.30 allows for inspection of the records by the commissioner during normal business hours:

398.1 (i) a daily census record, which indicates the number of children currently receiving
398.2 services at the center;

398.3 (ii) a record of all accidents or unusual incidents involving any child or staff member
398.4 that caused, or had the potential to cause, injury or harm to a person at the center or to center
398.5 property;

398.6 (iii) copies of all current agreements with providers of supportive services or contracted
398.7 services;

398.8 (iv) copies of all current agreements with consultants employed by the center,
398.9 documentation of each consultant's visits, and written, dated reports; and

398.10 (v) a personnel record for each employee, which must include an application for
398.11 employment, references, employment history for the preceding five years, and copies of all
398.12 performance evaluations;

398.13 (3) develop and maintain a current job description for each employee;

398.14 (4) provide necessary qualified personnel and ancillary services to ensure the health,
398.15 safety, and proper care for each child; and

398.16 (5) develop and implement infection control policies that comply with rules adopted by
398.17 the commissioner regarding infection control.

398.18 **Sec. 44. [144H.09] ADMISSION, TRANSFER, AND DISCHARGE POLICIES;**
398.19 **CONSENT FORM.**

398.20 Subdivision 1. **Written policies.** A PPEC center must have written policies and
398.21 procedures governing the admission, transfer, and discharge of children.

398.22 Subd. 2. **Notice of discharge.** At least ten days prior to a child's discharge from a PPEC
398.23 center, the PPEC center shall provide notice of the discharge to the child's parent or guardian.

398.24 Subd. 3. **Consent form.** A parent or guardian must sign a consent form outlining the
398.25 purpose of a PPEC center, specifying family responsibilities, authorizing treatment and
398.26 services, providing appropriate liability releases, and specifying emergency disposition
398.27 plans, before the child's admission to the center. The center must provide the child's parents
398.28 or guardians with a copy of the consent form and must maintain the consent form in the
398.29 child's medical record.

399.1 Sec. 45. [144H.10] MEDICAL DIRECTOR.

399.2 A PPEC center must have a medical director who is a physician licensed in Minnesota
399.3 and certified by the American Board of Pediatrics.

399.4 Sec. 46. [144H.11] NURSING SERVICES.

399.5 Subdivision 1. Nursing director. A PPEC center must have a nursing director who is
399.6 a registered nurse licensed in Minnesota, holds a current certification in cardiopulmonary
399.7 resuscitation, and has at least four years of general pediatric nursing experience, at least
399.8 one year of which must have been spent caring for medically fragile infants or children in
399.9 a pediatric intensive care, neonatal intensive care, PPEC center, or home care setting during
399.10 the previous five years. The nursing director is responsible for the daily operation of the
399.11 PPEC center.

399.12 Subd. 2. Registered nurses. A registered nurse employed by a PPEC center must be a
399.13 registered nurse licensed in Minnesota, hold a current certification in cardiopulmonary
399.14 resuscitation, and have experience in the previous 24 months in being responsible for the
399.15 care of acutely ill or chronically ill children.

399.16 Subd. 3. Licensed practical nurses. A licensed practical nurse employed by a PPEC
399.17 center must be supervised by a registered nurse and must be a licensed practical nurse
399.18 licensed in Minnesota, have at least two years of experience in pediatrics, and hold a current
399.19 certification in cardiopulmonary resuscitation.

399.20 Subd. 4. Other direct care personnel. (a) Direct care personnel governed by this
399.21 subdivision include nursing assistants and individuals with training and experience in the
399.22 field of education, social services, or child care.

399.23 (b) All direct care personnel employed by a PPEC center must work under the supervision
399.24 of a registered nurse and are responsible for providing direct care to children at the center.
399.25 Direct care personnel must have extensive, documented education and skills training in
399.26 providing care to infants and toddlers, provide employment references documenting skill
399.27 in the care of infants and children, and hold a current certification in cardiopulmonary
399.28 resuscitation.

400.1 Sec. 47. **[144H.12] TOTAL STAFFING FOR NURSING SERVICES AND DIRECT**
400.2 **CARE PERSONNEL.**

400.3 A PPEC center must provide total staffing for nursing services and direct care personnel
400.4 at a ratio of one staff person for every three children at the center. The staffing ratio required
400.5 in this section is the minimum staffing permitted.

400.6 Sec. 48. **[144H.13] MEDICAL RECORD; PROTOCOL OF CARE.**

400.7 A medical record and an individualized nursing protocol of care must be developed for
400.8 each child admitted to a PPEC center, must be maintained for each child, and must be signed
400.9 by authorized personnel.

400.10 Sec. 49. **[144H.14] QUALITY ASSURANCE PROGRAM.**

400.11 A PPEC center must have a quality assurance program, in which quarterly reviews are
400.12 conducted of the PPEC center's medical records and protocols of care for at least half of
400.13 the children served by the PPEC center. The quarterly review sample must be randomly
400.14 selected so each child at the center has an equal opportunity to be included in the review.
400.15 The committee conducting quality assurance reviews must include the medical director,
400.16 administrator, nursing director, and three other committee members determined by the PPEC
400.17 center.

400.18 Sec. 50. **[144H.15] INSPECTIONS.**

400.19 (a) The commissioner may inspect a PPEC center, including records held at the center,
400.20 at reasonable times as necessary to ensure compliance with this chapter and the rules that
400.21 apply to PPEC centers. During an inspection, a center must provide the commissioner with
400.22 access to all center records.

400.23 (b) The commissioner must inspect a PPEC center before issuing or renewing a license
400.24 under this chapter.

400.25 Sec. 51. **[144H.16] COMPLIANCE WITH OTHER LAWS.**

400.26 Subdivision 1. **Reporting of maltreatment of minors.** A PPEC center must develop
400.27 policies and procedures for reporting suspected child maltreatment that fulfill the
400.28 requirements of section 626.556. The policies and procedures must include the telephone
400.29 numbers of the local county child protection agency for reporting suspected maltreatment.
400.30 The policies and procedures specified in this subdivision must be provided to the parents

401.1 or guardians of all children at the time of admission to the PPEC center and must be available
401.2 upon request.

401.3 Subd. 2. **Crib safety requirements.** A PPEC center must comply with the crib safety
401.4 requirements in section 245A.146, to the extent they are applicable.

401.5 Sec. 52. **[144H.17] DENIAL, SUSPENSION, REVOCATION, REFUSAL TO RENEW**
401.6 **A LICENSE.**

401.7 (a) The commissioner may deny, suspend, revoke, or refuse to renew a license issued
401.8 under this chapter for:

401.9 (1) a violation of this chapter or rules adopted that apply to PPEC centers; or

401.10 (2) an intentional or negligent act by an employee or contractor at the center that
401.11 detrimentally affects the health or safety of children at the PPEC center.

401.12 (b) Prior to any suspension, revocation, or refusal to renew a license, a licensee shall be
401.13 entitled to a hearing and review as provided in sections 14.57 to 14.69.

401.14 Sec. 53. **[144H.18] FINES; CORRECTIVE ACTION PLANS.**

401.15 Subdivision 1. **Corrective action plans.** If the commissioner determines that a PPEC
401.16 center is not in compliance with this chapter or rules that apply to PPEC centers, the
401.17 commissioner may require the center to submit a corrective action plan that demonstrates
401.18 a good-faith effort to remedy each violation by a specific date, subject to approval by the
401.19 commissioner.

401.20 Subd. 2. **Fines.** The commissioner may issue a fine to a PPEC center, employee, or
401.21 contractor if the commissioner determines the center, employee, or contractor violated this
401.22 chapter or rules that apply to PPEC centers. The fine amount shall not exceed an amount
401.23 for each violation and an aggregate amount established by the commissioner. The failure
401.24 to correct a violation by the date set by the commissioner, or a failure to comply with an
401.25 approved corrective action plan, constitutes a separate violation for each day the failure
401.26 continues, unless the commissioner approves an extension to a specific date. In determining
401.27 if a fine is to be imposed and establishing the amount of the fine, the commissioner shall
401.28 consider:

401.29 (1) the gravity of the violation, including the probability that death or serious physical
401.30 or emotional harm to a child will result or has resulted, the severity of the actual or potential
401.31 harm, and the extent to which the applicable laws were violated;

402.1 (2) actions taken by the owner or administrator to correct violations;

402.2 (3) any previous violations; and

402.3 (4) the financial benefit to the PPEC center of committing or continuing the violation.

402.4 Subd. 3. **Fines for violations of other statutes.** The commissioner shall impose a fine
402.5 of \$250 on a PPEC center, employee, or contractor for each violation by that PPEC center,
402.6 employee, or contractor of section 144H.16, subdivision 2, or 626.556.

402.7 Sec. 54. **[144H.19] CLOSING A PPEC CENTER.**

402.8 When a PPEC center voluntarily closes, it must, at least 30 days before closure, inform
402.9 each child's parents or guardians of the closure and when the closure will occur.

402.10 Sec. 55. **[144H.20] PHYSICAL ENVIRONMENT.**

402.11 Subdivision 1. **General requirements.** A PPEC center shall conform with or exceed
402.12 the physical environment requirements in this section and the physical environment
402.13 requirements for day care facilities in Minnesota Rules, part 9502.0425. If the physical
402.14 environment requirements in this section differ from the physical environment requirements
402.15 for day care facilities in Minnesota Rules, part 9502.0425, the requirements in this section
402.16 shall prevail. A PPEC center must have sufficient indoor and outdoor space to accommodate
402.17 at least six medically complex or technologically dependent children.

402.18 Subd. 2. **Specific requirements.** (a) The entrance to a PPEC center must be barrier-free,
402.19 have a wheelchair ramp, provide for traffic flow with a driveway area for entering and
402.20 exiting, and have storage space for supplies from home.

402.21 (b) A PPEC center must have a treatment room with a medication preparation area. The
402.22 medication preparation area must contain a work counter, refrigerator, sink with hot and
402.23 cold running water, and locked storage for biologicals and prescription drugs.

402.24 (c) A PPEC center must develop isolation procedures to prevent cross-infections and
402.25 must have an isolation room with at least one glass area for observation of a child in the
402.26 isolation room. The isolation room must be at least 100 square feet in size.

402.27 (d) A PPEC center must have:

402.28 (1) an outdoor play space adjacent to the center of at least 35 square feet per child in
402.29 attendance at the center, for regular use; or

402.30 (2) a park, playground, or play space within 1,500 feet of the center.

403.1 (e) A PPEC center must have at least 50 square feet of usable indoor space per child in
403.2 attendance at the center.

403.3 (f) Notwithstanding the Minnesota State Building Code and the Minnesota State Fire
403.4 Code, a new construction PPEC center or an existing building converted into a PPEC center
403.5 must meet the requirements of the International Building Code in Minnesota Rules, chapter
403.6 1305, for:

403.7 (1) Group R, Division 4 occupancy, if serving 12 or fewer children; or

403.8 (2) Group E, Division 4 occupancy or Group I, Division 4 occupancy, if serving 13 or
403.9 more children.

403.10 Sec. 56. Minnesota Statutes 2016, section 145.4131, subdivision 1, is amended to read:

403.11 Subdivision 1. **Forms.** (a) Within 90 days of July 1, 1998, the commissioner shall prepare
403.12 a reporting form for use by physicians or facilities performing abortions. A copy of this
403.13 section shall be attached to the form. A physician or facility performing an abortion shall
403.14 obtain a form from the commissioner.

403.15 (b) The form shall require the following information:

403.16 (1) the number of abortions performed by the physician in the previous calendar year,
403.17 reported by month;

403.18 (2) the method used for each abortion;

403.19 (3) the approximate gestational age expressed in one of the following increments:

403.20 (i) less than nine weeks;

403.21 (ii) nine to ten weeks;

403.22 (iii) 11 to 12 weeks;

403.23 (iv) 13 to 15 weeks;

403.24 (v) 16 to 20 weeks;

403.25 (vi) 21 to 24 weeks;

403.26 (vii) 25 to 30 weeks;

403.27 (viii) 31 to 36 weeks; or

403.28 (ix) 37 weeks to term;

403.29 (4) the age of the woman at the time the abortion was performed;

- 404.1 (5) the specific reason for the abortion, including, but not limited to, the following:
- 404.2 (i) the pregnancy was a result of rape;
- 404.3 (ii) the pregnancy was a result of incest;
- 404.4 (iii) economic reasons;
- 404.5 (iv) the woman does not want children at this time;
- 404.6 (v) the woman's emotional health is at stake;
- 404.7 (vi) the woman's physical health is at stake;
- 404.8 (vii) the woman will suffer substantial and irreversible impairment of a major bodily
- 404.9 function if the pregnancy continues;
- 404.10 (viii) the pregnancy resulted in fetal anomalies; or
- 404.11 (ix) unknown or the woman refused to answer;
- 404.12 (6) the number of prior induced abortions;
- 404.13 (7) the number of prior spontaneous abortions;
- 404.14 (8) whether the abortion was paid for by:
- 404.15 (i) private coverage;
- 404.16 (ii) public assistance health coverage; or
- 404.17 (iii) self-pay;
- 404.18 (9) whether coverage was under:
- 404.19 (i) a fee-for-service plan;
- 404.20 (ii) a capitated private plan; or
- 404.21 (iii) other;
- 404.22 (10) complications, if any, for each abortion and for the aftermath of each abortion.
- 404.23 Space for a description of any complications shall be available on the form;
- 404.24 (11) the medical specialty of the physician performing the abortion; ~~and~~
- 404.25 (12) if the abortion was performed via telemedicine, the facility code for the patient and
- 404.26 the facility code for the physician; and
- 404.27 ~~(12)~~ (13) whether the abortion resulted in a born alive infant, as defined in section
- 404.28 145.423, subdivision 4, and:

- 405.1 (i) any medical actions taken to preserve the life of the born alive infant;
- 405.2 (ii) whether the born alive infant survived; and
- 405.3 (iii) the status of the born alive infant, should the infant survive, if known.

405.4 **EFFECTIVE DATE.** This section is effective January 1, 2018.

405.5 Sec. 57. Minnesota Statutes 2016, section 145.4716, subdivision 2, is amended to read:

405.6 Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible
405.7 for the following:

405.8 (1) developing and providing comprehensive training on sexual exploitation of youth
405.9 for social service professionals, medical professionals, public health workers, and criminal
405.10 justice professionals;

405.11 (2) collecting, organizing, maintaining, and disseminating information on sexual
405.12 exploitation and services across the state, including maintaining a list of resources on the
405.13 Department of Health Web site;

405.14 (3) monitoring and applying for federal funding for antitrafficking efforts that may
405.15 benefit victims in the state;

405.16 (4) managing grant programs established under sections 145.4716 to 145.4718, ~~and~~
405.17 609.3241, paragraph (c), clause (3); and 609.5315, subdivision 5c, clause (3);

405.18 (5) managing the request for proposals for grants for comprehensive services, including
405.19 trauma-informed, culturally specific services;

405.20 (6) identifying best practices in serving sexually exploited youth, as defined in section
405.21 260C.007, subdivision 31;

405.22 (7) providing oversight of and technical support to regional navigators pursuant to section
405.23 145.4717;

405.24 (8) conducting a comprehensive evaluation of the statewide program for safe harbor of
405.25 sexually exploited youth; and

405.26 (9) developing a policy consistent with the requirements of chapter 13 for sharing data
405.27 related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among
405.28 regional navigators and community-based advocates.

406.1 Sec. 58. [145.9263] OPIOID PRESCRIBER EDUCATION AND PUBLIC
406.2 AWARENESS GRANTS.

406.3 The commissioner of health, in coordination with the commissioner of human services,
406.4 shall award grants to nonprofit organizations for the purpose of expanding prescriber
406.5 education, public awareness and outreach on the opioid epidemic and overdose prevention
406.6 programs. The grantees must coordinate with health care systems, professional associations,
406.7 and emergency medical services providers. Each grantee receiving funds under this section
406.8 shall report to the commissioner on how the funds were spent and the outcomes achieved.

406.9 Sec. 59. Minnesota Statutes 2016, section 145.928, subdivision 13, is amended to read:

406.10 Subd. 13. **Reports.** (a) The commissioner shall submit a biennial report to the legislature
406.11 on the local community projects, tribal government, and community health board prevention
406.12 activities funded under this section. These reports must include information on grant
406.13 recipients, activities that were conducted using grant funds, evaluation data, and outcome
406.14 measures, if available. These reports are due by January 15 of every other year, beginning
406.15 in the year 2003.

406.16 (b) The commissioner shall release an annual report to the public and submit an the
406.17 annual report to the chairs and ranking minority members of the house of representatives
406.18 and senate committees with jurisdiction over public health on grants made under subdivision
406.19 7 to decrease racial and ethnic disparities in infant mortality rates. The report must provide
406.20 specific information on the amount of each grant awarded to each agency or organization,
406.21 an itemized list submitted to the commissioner by each agency or organization awarded a
406.22 grant specifying all uses of grant funds and the amount expended for each use, the population
406.23 served by each agency or organization, outcomes of the programs funded by each grant,
406.24 and the amount of the appropriation retained by the commissioner for administrative and
406.25 associated expenses. The commissioner shall issue a report each January 15 for the previous
406.26 fiscal year beginning January 15, 2016.

406.27 Sec. 60. Minnesota Statutes 2016, section 145.986, subdivision 1a, is amended to read:

406.28 Subd. 1a. **Grants to local communities.** (a) Beginning July 1, 2009, the commissioner
406.29 of health shall award competitive grants to community health boards and tribal governments
406.30 to convene, coordinate, and implement evidence-based strategies targeted at reducing the
406.31 percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.
406.32 Grants shall be awarded to all community health boards and tribal governments whose

407.1 proposals demonstrate the ability to implement programs designed to achieve the purposes
407.2 in subdivision 1 and other requirements of this section.

407.3 (b) Grantee activities shall:

407.4 (1) be based on scientific evidence;

407.5 (2) be based on community input;

407.6 (3) address behavior change at the individual, community, and systems levels;

407.7 (4) occur in community, school, work site, and health care settings;

407.8 (5) be focused on policy, systems, and environmental changes that support healthy
407.9 behaviors; and

407.10 (6) address the health disparities and inequities that exist in the grantee's community.

407.11 (c) To receive a grant under this section, community health boards and tribal governments
407.12 must submit proposals to the commissioner. A local match of ten percent of the total funding
407.13 allocation is required. This local match may include funds donated by community partners.

407.14 (d) In order to receive a grant, community health boards and tribal governments must
407.15 submit a health improvement plan to the commissioner of health for approval. The
407.16 commissioner may require the plan to identify a community leadership team, community
407.17 partners, and a community action plan that includes an assessment of area strengths and
407.18 needs, proposed action strategies, technical assistance needs, and a staffing plan.

407.19 (e) The grant recipient must implement the health improvement plan, evaluate the
407.20 effectiveness of the strategies, and modify or discontinue strategies found to be ineffective.

407.21 (f) Grant recipients shall report their activities and their progress toward the outcomes
407.22 established under subdivision 2 to the commissioner in a format and at a time specified by
407.23 the commissioner.

407.24 (g) All grant recipients shall be held accountable for making progress toward the
407.25 measurable outcomes established in subdivision 2. The commissioner shall require a
407.26 corrective action plan and may reduce the funding level of grant recipients that do not make
407.27 adequate progress toward the measurable outcomes.

407.28 (h) Beginning November 1, 2015, the commissioner shall offer grant recipients the
407.29 option of using a grant awarded under this subdivision to implement health improvement
407.30 strategies that improve the health status, delay the expression of dementia, or slow the
407.31 progression of dementia, for a targeted population at risk for dementia and shall award at
407.32 least two of the grants awarded on November 1, 2015, for these purposes. The grants must

408.1 meet all other requirements of this section. The commissioner shall coordinate grant planning
408.2 activities with the commissioner of human services, the Minnesota Board on Aging, and
408.3 community-based organizations with a focus on dementia. Each grant must include selected
408.4 outcomes and evaluation measures related to the incidence or progression of dementia
408.5 among the targeted population using the procedure described in subdivision 2.

408.6 (i) Beginning July 1, 2017, the commissioner shall offer grant recipients the option of
408.7 using a grant awarded under this subdivision to confront the opioid addiction and overdose
408.8 epidemic, and shall award at least two of the grants awarded on or after July 1, 2017, for
408.9 these purposes. The grants awarded under this paragraph must meet all other requirements
408.10 of this section. The commissioner shall coordinate grant planning activities with the
408.11 commissioner of human services. Each grant shall include selected outcomes and evaluation
408.12 measures related to addressing the opioid epidemic.

408.13 Sec. 61. Minnesota Statutes 2016, section 148.5194, subdivision 7, is amended to read:

408.14 Subd. 7. **Audiologist biennial licensure fee.** ~~(a)~~ The licensure fee for initial applicants
408.15 is \$435. The biennial licensure fee for audiologists for clinical fellowship, doctoral externship,
408.16 temporary, ~~initial applicants,~~ and renewal ~~licensees~~ licenses is \$435.

408.17 ~~(b) The audiologist fee is for practical examination costs greater than audiologist exam~~
408.18 ~~fee receipts and for complaint investigation, enforcement action, and consumer information~~
408.19 ~~and assistance expenditures related to hearing instrument dispensing.~~

408.20 Sec. 62. Minnesota Statutes 2016, section 152.25, subdivision 1, is amended to read:

408.21 Subdivision 1. **Medical cannabis manufacturer registration.** (a) The commissioner
408.22 shall register two in-state manufacturers for the production of all medical cannabis within
408.23 the state by December 1, 2014, unless the commissioner obtains an adequate supply of
408.24 federally sourced medical cannabis by August 1, 2014. The commissioner shall register
408.25 new manufacturers or reregister the existing manufacturers by December 1 every two years,
408.26 using the factors described in ~~paragraph~~ paragraphs (c) and (d). The commissioner shall
408.27 continue to accept applications after December 1, 2014, if two manufacturers that meet the
408.28 qualifications set forth in this subdivision do not apply before December 1, 2014. The
408.29 commissioner's determination that no manufacturer exists to fulfill the duties under sections
408.30 152.22 to 152.37 is subject to judicial review in Ramsey County District Court. Data
408.31 submitted during the application process are private data on individuals or nonpublic data
408.32 as defined in section 13.02 until the manufacturer is registered under this section. Data on

409.1 a manufacturer that is registered are public data, unless the data are trade secret or security
409.2 information under section 13.37.

409.3 (b) As a condition for registration, a manufacturer must agree to:

409.4 (1) begin supplying medical cannabis to patients by July 1, 2015; and

409.5 (2) comply with all requirements under sections 152.22 to 152.37.

409.6 (c) The commissioner shall consider the following factors when determining which
409.7 manufacturer to register:

409.8 (1) the technical expertise of the manufacturer in cultivating medical cannabis and
409.9 converting the medical cannabis into an acceptable delivery method under section 152.22,
409.10 subdivision 6;

409.11 (2) the qualifications of the manufacturer's employees;

409.12 (3) the long-term financial stability of the manufacturer;

409.13 (4) the ability to provide appropriate security measures on the premises of the
409.14 manufacturer;

409.15 (5) whether the manufacturer has demonstrated an ability to meet the medical cannabis
409.16 production needs required by sections 152.22 to 152.37; and

409.17 (6) the manufacturer's projection and ongoing assessment of fees on patients with a
409.18 qualifying medical condition.

409.19 (d) The commissioner shall not renew the registration of an existing manufacturer if an
409.20 officer, director, or controlling person of the manufacturer pleads or is found guilty of
409.21 intentionally diverting medical cannabis to a person other than allowed by law under section
409.22 152.33, subdivision 1, provided the violation occurred while the person was an officer,
409.23 director, or controlling person of the manufacturer.

409.24 ~~(d)~~ (e) The commissioner shall require each medical cannabis manufacturer to contract
409.25 with an independent laboratory to test medical cannabis produced by the manufacturer. The
409.26 commissioner shall approve the laboratory chosen by each manufacturer and require that
409.27 the laboratory report testing results to the manufacturer in a manner determined by the
409.28 commissioner.

409.29 **EFFECTIVE DATE.** This section is effective the day following final enactment.

410.1 Sec. 63. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision to
410.2 read:

410.3 Subd. 1a. **Revocation, nonrenewal, or denial of consent to transfer a medical cannabis**
410.4 **manufacturer registration.** If the commissioner intends to revoke, not renew, or deny
410.5 consent to transfer a registration issued under this section, the commissioner must first notify
410.6 in writing the manufacturer against whom the action is to be taken and provide the
410.7 manufacturer with an opportunity to request a hearing under the contested case provisions
410.8 of chapter 14. If the manufacturer does not request a hearing by notifying the commissioner
410.9 in writing within 20 days after receipt of the notice of proposed action, the commissioner
410.10 may proceed with the action without a hearing. For revocations, the registration of a
410.11 manufacturer is considered revoked on the date specified in the commissioner's written
410.12 notice of revocation.

410.13 **EFFECTIVE DATE.** This section is effective the day following final enactment.

410.14 Sec. 64. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision to
410.15 read:

410.16 Subd. 1b. **Temporary suspension proceedings.** The commissioner may institute
410.17 proceedings to temporarily suspend the registration of a medical cannabis manufacturer for
410.18 a period of up to 90 days by notifying the manufacturer in writing if any action by an officer,
410.19 director, or controlling person of the manufacturer:

410.20 (1) violates any of the requirements of sections 152.21 to 152.37 or the rules adopted
410.21 thereunder;

410.22 (2) permits, aids, or abets the commission of any violation of state law at the
410.23 manufacturer's location for cultivation, harvesting, manufacturing, packaging, and processing
410.24 or at any site for distribution of medical cannabis;

410.25 (3) performs any act contrary to the welfare of a patient or registered designated caregiver;
410.26 or

410.27 (4) obtains, or attempts to obtain, a registration by fraudulent means or misrepresentation.

410.28 **EFFECTIVE DATE.** This section is effective the day following final enactment.

411.1 Sec. 65. Minnesota Statutes 2016, section 152.25, is amended by adding a subdivision to
411.2 read:

411.3 Subd. 1c. **Notice to patients.** Upon the revocation or nonrenewal of a manufacturer's
411.4 registration under subdivision 1a or temporary suspension under subdivision 1b, the
411.5 commissioner shall notify in writing each patient and the patient's registered designated
411.6 caregiver or registered parent or legal guardian about the outcome of the proceeding and
411.7 information regarding alternative registered manufacturers. This notice must be provided
411.8 two or more business days prior to the effective date of the revocation, nonrenewal, or
411.9 suspension.

411.10 **EFFECTIVE DATE.** This section is effective the day following final enactment.

411.11 Sec. 66. Minnesota Statutes 2016, section 152.33, is amended by adding a subdivision to
411.12 read:

411.13 Subd. 1a. **Intentional diversion outside the state; penalties.** In addition to any other
411.14 applicable penalty in law, the commissioner shall levy a fine of \$500,000 against a
411.15 manufacturer and immediately initiate proceedings to revoke the manufacturer's registration,
411.16 using the procedure in section 152.25, subdivision 1a, if:

411.17 (1) an officer, director, or controlling person of the manufacturer pleads or is found
411.18 guilty under subdivision 1 of intentionally transferring medical cannabis, while the person
411.19 was an officer, director, or controlling person of the manufacturer, to a person other than
411.20 allowed by law; and

411.21 (2) in intentionally transferring medical cannabis to a person other than allowed by law,
411.22 the officer, director, or controlling person transported or directed the transport of medical
411.23 cannabis outside of Minnesota.

411.24 **EFFECTIVE DATE.** This section is effective the day following final enactment, and
411.25 applies to crimes committed on or after that date.

411.26 Sec. 67. Minnesota Statutes 2016, section 157.16, subdivision 1, is amended to read:

411.27 Subdivision 1. **License required annually.** A license is required annually for every
411.28 person, firm, or corporation engaged in the business of conducting a food and beverage
411.29 service establishment, youth camp, hotel, motel, lodging establishment, public pool, or
411.30 resort. Any person wishing to operate a place of business licensed in this section shall first
411.31 make application, pay the required fee specified in this section, and receive approval for
411.32 operation, including plan review approval. Special event food stands are not required to

412.1 submit plans. Nonprofit organizations operating a special event food stand with multiple
412.2 locations at an annual one-day event shall be issued only one license. Application shall be
412.3 made on forms provided by the commissioner and shall require the applicant to state the
412.4 full name and address of the owner of the building, structure, or enclosure, the lessee and
412.5 manager of the food and beverage service establishment, hotel, motel, lodging establishment,
412.6 public pool, or resort; the name under which the business is to be conducted; and any other
412.7 information as may be required by the commissioner to complete the application for license.
412.8 All fees collected under this section shall be deposited in the state government special
412.9 revenue fund.

412.10 Sec. 68. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
412.11 to read:

412.12 Subd. 65. **Prescribed pediatric extended care centers.** Medical assistance covers
412.13 services provided at a prescribed pediatric extended care center licensed under chapter
412.14 144H, when the services are provided in accordance with this chapter.

412.15 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
412.16 of human services shall notify the revisor of statutes when federal approval is obtained.

412.17 Sec. 69. **[256B.7651] PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS.**

412.18 The commissioner shall set payment rates for services provided at prescribed pediatric
412.19 extended care centers licensed under chapter 144H in one-hour increments, at a rate equal
412.20 to 85 percent of the payment rate for one hour of complex home care nursing services. The
412.21 payment rate shall include services provided by nursing staff and direct care staff specified
412.22 in section 144H.11.

412.23 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
412.24 of human services shall notify the revisor of statutes when federal approval is obtained.

412.25 Sec. 70. Minnesota Statutes 2016, section 327.15, subdivision 3, is amended to read:

412.26 Subd. 3. **Fees, manufactured home parks and recreational camping areas.** (a) The
412.27 following fees are required for manufactured home parks and recreational camping areas
412.28 licensed under this chapter. Fees collected under this section shall be deposited in the state
412.29 government special revenue fund. Recreational camping areas and manufactured home
412.30 parks shall pay the highest applicable base fee under paragraph (b). The license fee for new
412.31 operators of a manufactured home park or recreational camping area previously licensed
412.32 under this chapter for the same calendar year is one-half of the appropriate annual license

413.1 fee, plus any penalty that may be required. The license fee for operators opening on or after
413.2 October 1 is one-half of the appropriate annual license fee, plus any penalty that may be
413.3 required.

413.4 (b) All manufactured home parks and recreational camping areas shall pay the following
413.5 annual base fee:

413.6 (1) a manufactured home park, \$150; and

413.7 (2) a recreational camping area with:

413.8 (i) 24 or less sites, \$50;

413.9 (ii) 25 to 99 sites, \$212; and

413.10 (iii) 100 or more sites, \$300.

413.11 In addition to the base fee, manufactured home parks and recreational camping areas shall
413.12 pay \$4 for each licensed site. This paragraph does not apply to special event recreational
413.13 camping areas. Operators of a manufactured home park or a recreational camping area also
413.14 licensed under section 157.16 for the same location shall pay only one base fee, whichever
413.15 is the highest of the base fees found in this section or section 157.16.

413.16 (c) In addition to the fee in paragraph (b), each manufactured home park or recreational
413.17 camping area shall pay an additional annual fee for each fee category specified in this
413.18 paragraph:

413.19 (1) Manufactured home parks and recreational camping areas with public swimming
413.20 pools and spas shall pay the appropriate fees specified in section 157.16.

413.21 (2) Individual private sewer or water, \$60. "Individual private water" means a fee category
413.22 with a water supply other than a community public water supply as defined in Minnesota
413.23 Rules, chapter 4720. "Individual private sewer" means a fee category with a subsurface
413.24 sewage treatment system which uses subsurface treatment and disposal.

413.25 (d) The following fees must accompany a plan review application for initial construction
413.26 of a manufactured home park or recreational camping area:

413.27 (1) for initial construction of less than 25 sites, \$375;

413.28 (2) for initial construction of 25 to 99 sites, \$400; and

413.29 (3) for initial construction of 100 or more sites, \$500.

413.30 (e) The following fees must accompany a plan review application when an existing
413.31 manufactured home park or recreational camping area is expanded:

414.1 (1) for expansion of less than 25 sites, \$250;

414.2 (2) for expansion of 25 to 99 sites, \$300; and

414.3 (3) for expansion of 100 or more sites, \$450.

414.4 Sec. 71. Minnesota Statutes 2016, section 609.5315, subdivision 5c, is amended to read:

414.5 Subd. 5c. **Disposition of money; prostitution.** Money forfeited under section 609.5312,
414.6 subdivision 1, paragraph (b), must be distributed as follows:

414.7 (1) 40 percent must be forwarded to the appropriate agency for deposit as a supplement
414.8 to the agency's operating fund or similar fund for use in law enforcement;

414.9 (2) 20 percent must be forwarded to the prosecuting authority that handled the forfeiture
414.10 for deposit as a supplement to its operating fund or similar fund for prosecutorial purposes;
414.11 and

414.12 (3) the remaining 40 percent must be forwarded to the commissioner of ~~public safety~~
414.13 health to be deposited in the safe harbor for youth account in the special revenue fund and
414.14 is appropriated to the commissioner for distribution to crime victims services organizations
414.15 that provide services to sexually exploited youth, as defined in section 260C.007, subdivision
414.16 31.

414.17 Sec. 72. Minnesota Statutes 2016, section 626.556, subdivision 2, is amended to read:

414.18 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
414.19 given them unless the specific content indicates otherwise:

414.20 (a) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence
414.21 or event which:

414.22 (1) is not likely to occur and could not have been prevented by exercise of due care; and

414.23 (2) if occurring while a child is receiving services from a facility, happens when the
414.24 facility and the employee or person providing services in the facility are in compliance with
414.25 the laws and rules relevant to the occurrence or event.

414.26 (b) "Commissioner" means the commissioner of human services.

414.27 (c) "Facility" means:

414.28 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
414.29 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
414.30 144.58, 241.021, or 245A.01 to 245A.16, or chapter 144H or 245D;

415.1 (2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E;
415.2 or

415.3 (3) a nonlicensed personal care provider organization as defined in section 256B.0625,
415.4 subdivision 19a.

415.5 (d) "Family assessment" means a comprehensive assessment of child safety, risk of
415.6 subsequent child maltreatment, and family strengths and needs that is applied to a child
415.7 maltreatment report that does not allege sexual abuse or substantial child endangerment.
415.8 Family assessment does not include a determination as to whether child maltreatment
415.9 occurred but does determine the need for services to address the safety of family members
415.10 and the risk of subsequent maltreatment.

415.11 (e) "Investigation" means fact gathering related to the current safety of a child and the
415.12 risk of subsequent maltreatment that determines whether child maltreatment occurred and
415.13 whether child protective services are needed. An investigation must be used when reports
415.14 involve sexual abuse or substantial child endangerment, and for reports of maltreatment in
415.15 facilities required to be licensed under chapter 245A or 245D; under sections 144.50 to
415.16 144.58 and 241.021; in a school as defined in section 120A.05, subdivisions 9, 11, and 13,
415.17 and chapter 124E; or in a nonlicensed personal care provider association as defined in section
415.18 256B.0625, subdivision 19a.

415.19 (f) "Mental injury" means an injury to the psychological capacity or emotional stability
415.20 of a child as evidenced by an observable or substantial impairment in the child's ability to
415.21 function within a normal range of performance and behavior with due regard to the child's
415.22 culture.

415.23 (g) "Neglect" means the commission or omission of any of the acts specified under
415.24 clauses (1) to (9), other than by accidental means:

415.25 (1) failure by a person responsible for a child's care to supply a child with necessary
415.26 food, clothing, shelter, health, medical, or other care required for the child's physical or
415.27 mental health when reasonably able to do so;

415.28 (2) failure to protect a child from conditions or actions that seriously endanger the child's
415.29 physical or mental health when reasonably able to do so, including a growth delay, which
415.30 may be referred to as a failure to thrive, that has been diagnosed by a physician and is due
415.31 to parental neglect;

415.32 (3) failure to provide for necessary supervision or child care arrangements appropriate
415.33 for a child after considering factors as the child's age, mental ability, physical condition,

416.1 length of absence, or environment, when the child is unable to care for the child's own basic
416.2 needs or safety, or the basic needs or safety of another child in their care;

416.3 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
416.4 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
416.5 child with sympathomimetic medications, consistent with section 125A.091, subdivision
416.6 5;

416.7 (5) nothing in this section shall be construed to mean that a child is neglected solely
416.8 because the child's parent, guardian, or other person responsible for the child's care in good
416.9 faith selects and depends upon spiritual means or prayer for treatment or care of disease or
416.10 remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker,
416.11 or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of
416.12 medical care may cause serious danger to the child's health. This section does not impose
416.13 upon persons, not otherwise legally responsible for providing a child with necessary food,
416.14 clothing, shelter, education, or medical care, a duty to provide that care;

416.15 (6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision
416.16 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in
416.17 the child at birth, results of a toxicology test performed on the mother at delivery or the
416.18 child at birth, medical effects or developmental delays during the child's first year of life
416.19 that medically indicate prenatal exposure to a controlled substance, or the presence of a
416.20 fetal alcohol spectrum disorder;

416.21 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

416.22 (8) chronic and severe use of alcohol or a controlled substance by a parent or person
416.23 responsible for the care of the child that adversely affects the child's basic needs and safety;
416.24 or

416.25 (9) emotional harm from a pattern of behavior which contributes to impaired emotional
416.26 functioning of the child which may be demonstrated by a substantial and observable effect
416.27 in the child's behavior, emotional response, or cognition that is not within the normal range
416.28 for the child's age and stage of development, with due regard to the child's culture.

416.29 (h) "Nonmaltreatment mistake" means:

416.30 (1) at the time of the incident, the individual was performing duties identified in the
416.31 center's child care program plan required under Minnesota Rules, part 9503.0045;

416.32 (2) the individual has not been determined responsible for a similar incident that resulted
416.33 in a finding of maltreatment for at least seven years;

417.1 (3) the individual has not been determined to have committed a similar nonmaltreatment
417.2 mistake under this paragraph for at least four years;

417.3 (4) any injury to a child resulting from the incident, if treated, is treated only with
417.4 remedies that are available over the counter, whether ordered by a medical professional or
417.5 not; and

417.6 (5) except for the period when the incident occurred, the facility and the individual
417.7 providing services were both in compliance with all licensing requirements relevant to the
417.8 incident.

417.9 This definition only applies to child care centers licensed under Minnesota Rules, chapter
417.10 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated
417.11 maltreatment by the individual, the commissioner of human services shall determine that a
417.12 nonmaltreatment mistake was made by the individual.

417.13 (i) "Operator" means an operator or agency as defined in section 245A.02.

417.14 (j) "Person responsible for the child's care" means (1) an individual functioning within
417.15 the family unit and having responsibilities for the care of the child such as a parent, guardian,
417.16 or other person having similar care responsibilities, or (2) an individual functioning outside
417.17 the family unit and having responsibilities for the care of the child such as a teacher, school
417.18 administrator, other school employees or agents, or other lawful custodian of a child having
417.19 either full-time or short-term care responsibilities including, but not limited to, day care,
417.20 babysitting whether paid or unpaid, counseling, teaching, and coaching.

417.21 (k) "Physical abuse" means any physical injury, mental injury, or threatened injury,
417.22 inflicted by a person responsible for the child's care on a child other than by accidental
417.23 means, or any physical or mental injury that cannot reasonably be explained by the child's
417.24 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
417.25 that have not been authorized under section 125A.0942 or 245.825.

417.26 Abuse does not include reasonable and moderate physical discipline of a child
417.27 administered by a parent or legal guardian which does not result in an injury. Abuse does
417.28 not include the use of reasonable force by a teacher, principal, or school employee as allowed
417.29 by section 121A.582. Actions which are not reasonable and moderate include, but are not
417.30 limited to, any of the following:

417.31 (1) throwing, kicking, burning, biting, or cutting a child;

417.32 (2) striking a child with a closed fist;

417.33 (3) shaking a child under age three;

418.1 (4) striking or other actions which result in any nonaccidental injury to a child under 18
418.2 months of age;

418.3 (5) unreasonable interference with a child's breathing;

418.4 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

418.5 (7) striking a child under age one on the face or head;

418.6 (8) striking a child who is at least age one but under age four on the face or head, which
418.7 results in an injury;

418.8 (9) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
418.9 substances which were not prescribed for the child by a practitioner, in order to control or
418.10 punish the child; or other substances that substantially affect the child's behavior, motor
418.11 coordination, or judgment or that results in sickness or internal injury, or subjects the child
418.12 to medical procedures that would be unnecessary if the child were not exposed to the
418.13 substances;

418.14 (10) unreasonable physical confinement or restraint not permitted under section 609.379,
418.15 including but not limited to tying, caging, or chaining; or

418.16 (11) in a school facility or school zone, an act by a person responsible for the child's
418.17 care that is a violation under section 121A.58.

418.18 (l) "Practice of social services," for the purposes of subdivision 3, includes but is not
418.19 limited to employee assistance counseling and the provision of guardian ad litem and
418.20 parenting time expeditor services.

418.21 (m) "Report" means any communication received by the local welfare agency, police
418.22 department, county sheriff, or agency responsible for child protection pursuant to this section
418.23 that describes neglect or physical or sexual abuse of a child and contains sufficient content
418.24 to identify the child and any person believed to be responsible for the neglect or abuse, if
418.25 known.

418.26 (n) "Sexual abuse" means the subjection of a child by a person responsible for the child's
418.27 care, by a person who has a significant relationship to the child, as defined in section 609.341,
418.28 or by a person in a position of authority, as defined in section 609.341, subdivision 10, to
418.29 any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first
418.30 degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual
418.31 conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or
418.32 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act
418.33 which involves a minor which constitutes a violation of prostitution offenses under sections

419.1 609.321 to 609.324 or 617.246. Effective May 29, 2017, sexual abuse includes all reports
419.2 of known or suspected child sex trafficking involving a child who is identified as a victim
419.3 of sex trafficking. Sexual abuse includes child sex trafficking as defined in section 609.321,
419.4 subdivisions 7a and 7b. Sexual abuse includes threatened sexual abuse which includes the
419.5 status of a parent or household member who has committed a violation which requires
419.6 registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or
419.7 required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

419.8 (o) "Substantial child endangerment" means a person responsible for a child's care, by
419.9 act or omission, commits or attempts to commit an act against a child under their care that
419.10 constitutes any of the following:

419.11 (1) egregious harm as defined in section 260C.007, subdivision 14;

419.12 (2) abandonment under section 260C.301, subdivision 2;

419.13 (3) neglect as defined in paragraph (g), clause (2), that substantially endangers the child's
419.14 physical or mental health, including a growth delay, which may be referred to as failure to
419.15 thrive, that has been diagnosed by a physician and is due to parental neglect;

419.16 (4) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

419.17 (5) manslaughter in the first or second degree under section 609.20 or 609.205;

419.18 (6) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

419.19 (7) solicitation, inducement, and promotion of prostitution under section 609.322;

419.20 (8) criminal sexual conduct under sections 609.342 to 609.3451;

419.21 (9) solicitation of children to engage in sexual conduct under section 609.352;

419.22 (10) malicious punishment or neglect or endangerment of a child under section 609.377
419.23 or 609.378;

419.24 (11) use of a minor in sexual performance under section 617.246; or

419.25 (12) parental behavior, status, or condition which mandates that the county attorney file
419.26 a termination of parental rights petition under section 260C.503, subdivision 2.

419.27 (p) "Threatened injury" means a statement, overt act, condition, or status that represents
419.28 a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes,
419.29 but is not limited to, exposing a child to a person responsible for the child's care, as defined
419.30 in paragraph (j), clause (1), who has:

420.1 (1) subjected a child to, or failed to protect a child from, an overt act or condition that
420.2 constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law
420.3 of another jurisdiction;

420.4 (2) been found to be palpably unfit under section 260C.301, subdivision 1, paragraph
420.5 (b), clause (4), or a similar law of another jurisdiction;

420.6 (3) committed an act that has resulted in an involuntary termination of parental rights
420.7 under section 260C.301, or a similar law of another jurisdiction; or

420.8 (4) committed an act that has resulted in the involuntary transfer of permanent legal and
420.9 physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201,
420.10 subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law
420.11 of another jurisdiction.

420.12 A child is the subject of a report of threatened injury when the responsible social services
420.13 agency receives birth match data under paragraph (q) from the Department of Human
420.14 Services.

420.15 (q) Upon receiving data under section 144.225, subdivision 2b, contained in a birth
420.16 record or recognition of parentage identifying a child who is subject to threatened injury
420.17 under paragraph (p), the Department of Human Services shall send the data to the responsible
420.18 social services agency. The data is known as "birth match" data. Unless the responsible
420.19 social services agency has already begun an investigation or assessment of the report due
420.20 to the birth of the child or execution of the recognition of parentage and the parent's previous
420.21 history with child protection, the agency shall accept the birth match data as a report under
420.22 this section. The agency may use either a family assessment or investigation to determine
420.23 whether the child is safe. All of the provisions of this section apply. If the child is determined
420.24 to be safe, the agency shall consult with the county attorney to determine the appropriateness
420.25 of filing a petition alleging the child is in need of protection or services under section
420.26 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is
420.27 determined not to be safe, the agency and the county attorney shall take appropriate action
420.28 as required under section 260C.503, subdivision 2.

420.29 (r) Persons who conduct assessments or investigations under this section shall take into
420.30 account accepted child-rearing practices of the culture in which a child participates and
420.31 accepted teacher discipline practices, which are not injurious to the child's health, welfare,
420.32 and safety.

421.1 Sec. 73. Minnesota Statutes 2016, section 626.556, subdivision 3, is amended to read:

421.2 Subd. 3. **Persons mandated to report; persons voluntarily reporting.** (a) A person
421.3 who knows or has reason to believe a child is being neglected or physically or sexually
421.4 abused, as defined in subdivision 2, or has been neglected or physically or sexually abused
421.5 within the preceding three years, shall immediately report the information to the local welfare
421.6 agency, agency responsible for assessing or investigating the report, police department,
421.7 county sheriff, tribal social services agency, or tribal police department if the person is:

421.8 (1) a professional or professional's delegate who is engaged in the practice of the healing
421.9 arts, social services, hospital administration, psychological or psychiatric treatment, child
421.10 care, education, correctional supervision, probation and correctional services, or law
421.11 enforcement; or

421.12 (2) employed as a member of the clergy and received the information while engaged in
421.13 ministerial duties, provided that a member of the clergy is not required by this subdivision
421.14 to report information that is otherwise privileged under section 595.02, subdivision 1,
421.15 paragraph (c).

421.16 (b) Any person may voluntarily report to the local welfare agency, agency responsible
421.17 for assessing or investigating the report, police department, county sheriff, tribal social
421.18 services agency, or tribal police department if the person knows, has reason to believe, or
421.19 suspects a child is being or has been neglected or subjected to physical or sexual abuse.

421.20 (c) A person mandated to report physical or sexual child abuse or neglect occurring
421.21 within a licensed facility shall report the information to the agency responsible for licensing
421.22 the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter 144H
421.23 or 245D; or a nonlicensed personal care provider organization as defined in section
421.24 256B.0625, subdivision ~~19~~ 19a. A health or corrections agency receiving a report may
421.25 request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and
421.26 10b. A board or other entity whose licensees perform work within a school facility, upon
421.27 receiving a complaint of alleged maltreatment, shall provide information about the
421.28 circumstances of the alleged maltreatment to the commissioner of education. Section 13.03,
421.29 subdivision 4, applies to data received by the commissioner of education from a licensing
421.30 entity.

421.31 (d) Notification requirements under subdivision 10 apply to all reports received under
421.32 this section.

421.33 (e) For purposes of this section, "immediately" means as soon as possible but in no event
421.34 longer than 24 hours.

422.1 Sec. 74. Minnesota Statutes 2016, section 626.556, subdivision 3c, is amended to read:

422.2 Subd. 3c. **Local welfare agency, Department of Human Services or Department of**
422.3 **Health responsible for assessing or investigating reports of maltreatment.** (a) The county
422.4 local welfare agency is the agency responsible for assessing or investigating allegations of
422.5 maltreatment in child foster care, family child care, legally unlicensed child care, juvenile
422.6 correctional facilities licensed under section 241.021 located in the local welfare agency's
422.7 county, and reports involving children served by an unlicensed personal care provider
422.8 organization under section 256B.0659. Copies of findings related to personal care provider
422.9 organizations under section 256B.0659 must be forwarded to the Department of Human
422.10 Services provider enrollment.

422.11 (b) The Department of Human Services is the agency responsible for assessing or
422.12 investigating allegations of maltreatment in facilities licensed under chapters 245A and
422.13 245D, except for child foster care and family child care.

422.14 (c) The Department of Health is the agency responsible for assessing or investigating
422.15 allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and
422.16 144A.43 to 144A.482 or chapter 144H.

422.17 Sec. 75. Minnesota Statutes 2016, section 626.556, subdivision 10d, is amended to read:

422.18 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received
422.19 that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the
422.20 care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
422.21 sanitarium, or other facility or institution required to be licensed according to sections 144.50
422.22 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter 144H or 245D, or a school as defined
422.23 in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or a nonlicensed personal
422.24 care provider organization as defined in section 256B.0625, subdivision 19a, the
422.25 commissioner of the agency responsible for assessing or investigating the report or local
422.26 welfare agency investigating the report shall provide the following information to the parent,
422.27 guardian, or legal custodian of a child alleged to have been neglected, physically abused,
422.28 sexually abused, or the victim of maltreatment of a child in the facility: the name of the
422.29 facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment
422.30 of a child in the facility has been received; the nature of the alleged neglect, physical abuse,
422.31 sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an
422.32 assessment or investigation; any protective or corrective measures being taken pending the
422.33 outcome of the investigation; and that a written memorandum will be provided when the
422.34 investigation is completed.

423.1 (b) The commissioner of the agency responsible for assessing or investigating the report
423.2 or local welfare agency may also provide the information in paragraph (a) to the parent,
423.3 guardian, or legal custodian of any other child in the facility if the investigative agency
423.4 knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or
423.5 maltreatment of a child in the facility has occurred. In determining whether to exercise this
423.6 authority, the commissioner of the agency responsible for assessing or investigating the
423.7 report or local welfare agency shall consider the seriousness of the alleged neglect, physical
423.8 abuse, sexual abuse, or maltreatment of a child in the facility; the number of children
423.9 allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a
423.10 child in the facility; the number of alleged perpetrators; and the length of the investigation.
423.11 The facility shall be notified whenever this discretion is exercised.

423.12 (c) When the commissioner of the agency responsible for assessing or investigating the
423.13 report or local welfare agency has completed its investigation, every parent, guardian, or
423.14 legal custodian previously notified of the investigation by the commissioner or local welfare
423.15 agency shall be provided with the following information in a written memorandum: the
423.16 name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual
423.17 abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the
423.18 investigation findings; a statement whether maltreatment was found; and the protective or
423.19 corrective measures that are being or will be taken. The memorandum shall be written in a
423.20 manner that protects the identity of the reporter and the child and shall not contain the name,
423.21 or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed
423.22 during the investigation. If maltreatment is determined to exist, the commissioner or local
423.23 welfare agency shall also provide the written memorandum to the parent, guardian, or legal
423.24 custodian of each child in the facility who had contact with the individual responsible for
423.25 the maltreatment. When the facility is the responsible party for maltreatment, the
423.26 commissioner or local welfare agency shall also provide the written memorandum to the
423.27 parent, guardian, or legal custodian of each child who received services in the population
423.28 of the facility where the maltreatment occurred. This notification must be provided to the
423.29 parent, guardian, or legal custodian of each child receiving services from the time the
423.30 maltreatment occurred until either the individual responsible for maltreatment is no longer
423.31 in contact with a child or children in the facility or the conclusion of the investigation. In
423.32 the case of maltreatment within a school facility, as defined in section 120A.05, subdivisions
423.33 9, 11, and 13, and chapter 124E, the commissioner of education need not provide notification
423.34 to parents, guardians, or legal custodians of each child in the facility, but shall, within ten
423.35 days after the investigation is completed, provide written notification to the parent, guardian,
423.36 or legal custodian of any student alleged to have been maltreated. The commissioner of

424.1 education may notify the parent, guardian, or legal custodian of any student involved as a
424.2 witness to alleged maltreatment.

424.3 **Sec. 76. BRAIN HEALTH PILOT PROGRAMS.**

424.4 **Subdivision 1. Pilot programs selected.** (a) The commissioner shall competitively
424.5 award grants for up to five pilot programs to improve brain health in youth sports in
424.6 Minnesota. The commissioner shall issue a competitive request for pilot program proposals
424.7 by October 31, 2017, based on input from the youth sports concussion working group. The
424.8 commissioner shall include members of the working group in the scoring of proposals
424.9 received, but shall exclude any member of the working group with a financial interest in a
424.10 pilot program proposal.

424.11 (b) Each pilot program selected for a funding award must offer promise for improving
424.12 at least one of the following areas:

424.13 (1) objective identification of brain injury;

424.14 (2) assessment and treatment of brain injury;

424.15 (3) coordination of school and medical support services; or

424.16 (4) policy reform to improve brain health outcomes.

424.17 (c) The programs must be selected so that youth are served in each of the following
424.18 regions of the state:

424.19 (1) Central or West Central Minnesota;

424.20 (2) Southern, Southwest, or Southeast Minnesota;

424.21 (3) Northwest or Northland Minnesota; and

424.22 (4) the Twin Cities Metropolitan Area.

424.23 **Subd. 2. Funding for pilot programs.** Pilot programs selected under this section shall
424.24 receive funding for one year beginning January 1, 2018. No later than March 1, 2019, the
424.25 commissioner must report on the progress and outcomes of the pilot programs to the
424.26 legislative committees with jurisdiction over health policy and finance.

424.27 **Sec. 77. RECOMMENDATIONS FOR SAFETY AND QUALITY IMPROVEMENT**
424.28 **PRACTICES FOR LONG-TERM CARE SERVICES AND SUPPORTS.**

424.29 The commissioner of health shall consult with interested stakeholders to explore and
424.30 make recommendations on how to apply proven safety and quality improvement practices

425.1 and infrastructure to long-term care services and supports. Interested stakeholders with
425.2 whom the commissioner must consult shall include but are not limited to representatives
425.3 of the Minnesota Alliance for Patient Safety partner organizations, the Office of Ombudsman
425.4 for Long-Term Care, the Minnesota Elder Justice Center, providers of older adult services,
425.5 the Department of Health, and the Department of Human Services, and experts in the field
425.6 of long-term care safety and quality improvement. The recommendations shall include
425.7 mechanisms to apply a patient safety model to the senior care sector, including a system
425.8 for reporting adverse health events, education and prevention activities, and interim actions
425.9 to improve systems for processing reports and complaints submitted to the Office of Health
425.10 Facility Complaints. By January 15, 2018, the commissioner shall submit the
425.11 recommendations developed under this section, along with draft legislation to implement
425.12 the recommendations, to the chairs and ranking minority members of the legislative
425.13 committees with jurisdiction over long-term care.

425.14 **Sec. 78. STUDY AND REPORT ON HOME CARE NURSING WORKFORCE**
425.15 **SHORTAGE.**

425.16 (a) The chair and ranking minority member of the senate Human Services Reform
425.17 Finance and Policy Committee and the chair and ranking minority member of the house of
425.18 representatives Health and Human Services Finance Committee shall convene a working
425.19 group to study and report on the shortage of registered nurses and licensed practical nurses
425.20 available to provide low-complexity regular home care services to clients in need of such
425.21 services, especially clients covered by medical assistance, and to provide recommendations
425.22 for ways to address the workforce shortage. The working group shall consist of 14 members
425.23 appointed as follows:

425.24 (1) the chair of the senate Human Services Reform Finance and Policy Committee or a
425.25 designee;

425.26 (2) the ranking minority member of the senate Human Services Reform Finance and
425.27 Policy Committee or a designee;

425.28 (3) the chair of the house of representatives Health and Human Services Finance
425.29 Committee or a designee;

425.30 (4) the ranking minority member of the house of representatives Health and Human
425.31 Services Finance Committee or a designee;

425.32 (5) the commissioner of human services or a designee;

425.33 (6) the commissioner of health or a designee;

- 426.1 (7) one representative appointed by the Professional Home Care Coalition;
- 426.2 (8) one representative appointed by the Minnesota Home Care Association;
- 426.3 (9) one representative appointed by the Minnesota Board of Nursing;
- 426.4 (10) one representative appointed by the Minnesota Nurses Association;
- 426.5 (11) one representative appointed by the Minnesota Licensed Practical Nurses
- 426.6 Association;
- 426.7 (12) one representative appointed by the Minnesota Society of Medical Assistants;
- 426.8 (13) one client who receives regular home care nursing services and is covered by medical
- 426.9 assistance appointed by the commissioner of human services after consulting with the
- 426.10 appointing authorities identified in clauses (7) to (12); and
- 426.11 (14) one assessor appointed by the commissioner of human services. The assessor must
- 426.12 be certified under Minnesota Statutes, section 256B.0911, and must be a registered nurse.
- 426.13 (b) The appointing authorities must appoint members by August 1, 2017.
- 426.14 (c) The convening authorities shall convene the first meeting of the working group no
- 426.15 later than August 15, 2017, and caucus staff shall provide support and meeting space for
- 426.16 the working group. The Department of Health and the Department of Human Services shall
- 426.17 provide technical assistance to the working group by providing existing data and analysis
- 426.18 documenting the current and projected workforce shortages in the area of regular home care
- 426.19 nursing. The home care and assisted living program advisory council established under
- 426.20 Minnesota Statutes, section 144A.4799, shall provide advice and recommendations to the
- 426.21 working group. Working group members shall serve without compensation and shall not
- 426.22 be reimbursed for expenses.
- 426.23 (d) The working group shall:
- 426.24 (1) quantify the number of low-complexity regular home care nursing hours that are
- 426.25 authorized but not provided to clients covered by medical assistance, due to the shortage
- 426.26 of registered nurses and licensed practical nurses available to provide these home care
- 426.27 services;
- 426.28 (2) quantify the current and projected workforce shortages of registered nurses and
- 426.29 licensed practical nurses available to provide low-complexity regular home care nursing
- 426.30 services to clients, especially clients covered by medical assistance;
- 426.31 (3) develop recommendations for actions to take in the next two years to address the
- 426.32 regular home care nursing workforce shortage, including identifying other health care

427.1 professionals who may be able to provide low-complexity regular home care nursing services
427.2 with additional training; what additional training may be necessary for these health care
427.3 professionals; and how to address scope of practice and licensing issues;

427.4 (4) compile reimbursement rates for regular home care nursing from other states and
427.5 determine Minnesota's national ranking with respect to reimbursement for regular home
427.6 care nursing;

427.7 (5) determine whether reimbursement rates for regular home care nursing fully reimburse
427.8 providers for the cost of providing the service and whether the discrepancy, if any, between
427.9 rates and costs contributes to lack of access to regular home care nursing; and

427.10 (6) by January 15, 2018, report on the findings and recommendations of the working
427.11 group to the chairs and ranking minority members of the legislative committees with
427.12 jurisdiction over health and human services policy and finance. The working group's report
427.13 shall include draft legislation.

427.14 (e) The working group shall elect a chair from among its members at its first meeting.

427.15 (f) The meetings of the working group shall be open to the public.

427.16 (g) This section expires January 16, 2018, or the day after submitting the report required
427.17 by this section, whichever is earlier.

427.18 **EFFECTIVE DATE.** This section is effective the day following final enactment.

427.19 **Sec. 79. OPIOID ABUSE PREVENTION PILOT PROJECTS.**

427.20 (a) The commissioner of health shall establish opioid abuse prevention pilot projects in
427.21 geographic areas throughout the state, to reduce opioid abuse through the use of controlled
427.22 substance care teams and community-wide coordination of abuse-prevention initiatives.

427.23 The commissioner shall award grants to health care providers, health plan companies, local
427.24 units of government, or other entities to establish pilot projects.

427.25 (b) Each pilot project must:

427.26 (1) be designed to reduce emergency room and other health care provider visits resulting
427.27 from opioid use or abuse, and reduce rates of opioid addiction in the community;

427.28 (2) establish multidisciplinary controlled substance care teams, that may consist of
427.29 physicians, pharmacists, social workers, nurse care coordinators, and mental health
427.30 professionals;

428.1 (3) deliver health care services and care coordination, through controlled substance care
428.2 teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;

428.3 (4) address any unmet social service needs that create barriers to managing pain
428.4 effectively and obtaining optimal health outcomes;

428.5 (5) provide prescriber and dispenser education and assistance to reduce the inappropriate
428.6 prescribing and dispensing of opioids;

428.7 (6) promote the adoption of best practices related to opioid disposal and reducing
428.8 opportunities for illegal access to opioids; and

428.9 (7) engage partners outside of the health care system, including schools, law enforcement,
428.10 and social services, to address root causes of opioid abuse and addiction at the community
428.11 level.

428.12 (c) The commissioner shall contract with an accountable community for health that
428.13 operates an opioid abuse prevention project, and can document success in reducing opioid
428.14 use through the use of controlled substance care teams, to assist the commissioner in
428.15 administering this section, and to provide technical assistance to the commissioner and to
428.16 entities selected to operate a pilot project.

428.17 (d) The contract under paragraph (c) shall require the accountable community for health
428.18 to evaluate the extent to which the pilot projects were successful in reducing the inappropriate
428.19 use of opioids. The evaluation must analyze changes in the number of opioid prescriptions,
428.20 the number of emergency room visits related to opioid use, and other relevant measures.
428.21 The accountable community for health shall report evaluation results to the chairs and
428.22 ranking minority members of the legislative committees with jurisdiction over health and
428.23 human services policy and finance and public safety by December 15, 2019.

428.24 **Sec. 80. SAFE HARBOR FOR ALL; STATEWIDE SEX TRAFFICKING VICTIMS**
428.25 **STRATEGIC PLAN.**

428.26 (a) By October 1, 2018, the commissioner of health, in consultation with the
428.27 commissioners of public safety and human services, shall adopt a comprehensive strategic
428.28 plan to address the needs of sex trafficking victims statewide.

428.29 (b) The commissioner of health shall issue a request for proposals to select an organization
428.30 to develop the comprehensive strategic plan. The selected organization shall seek
428.31 recommendations from professionals, community members, and stakeholders from across
428.32 the state, with an emphasis on the communities most impacted by sex trafficking. At a
428.33 minimum, the selected organization must seek input from the following groups: sex

429.1 trafficking survivors and their family members, statewide crime victim services coalitions,
429.2 victim services providers, nonprofit organizations, task forces, prosecutors, public defenders,
429.3 tribal governments, public safety and corrections professionals, public health professionals,
429.4 human services professionals, and impacted community members. The strategic plan shall
429.5 include recommendations regarding the expansion of Minnesota's Safe Harbor Law to adult
429.6 victims of sex trafficking.

429.7 (c) By January 15, 2019, the commissioner of health shall report to the chairs and ranking
429.8 minority members of the legislative committees with jurisdiction over health and human
429.9 services and criminal justice finance and policy on developing the statewide strategic plan,
429.10 including recommendations for additional legislation and funding.

429.11 (d) As used in this section, "sex trafficking victim" has the meaning given in Minnesota
429.12 Statutes, section 609.321, subdivision 7b.

429.13 **Sec. 81. DIRECTION TO THE COMMISSIONER OF HEALTH.**

429.14 The commissioner of health shall work with interested stakeholders to evaluate whether
429.15 existing laws, including laws governing housing with services establishments, board and
429.16 lodging establishments with special services, assisted living designations, and home care
429.17 providers, as well as building code requirements and landlord tenancy laws, sufficiently
429.18 protect the health and safety of persons diagnosed with Alzheimer's disease or a related
429.19 dementia.

429.20 **Sec. 82. PALLIATIVE CARE ADVISORY COUNCIL.**

429.21 The appointing authorities shall appoint the first members of the Palliative Care Advisory
429.22 Council under Minnesota Statutes, section 144.059, by October 1, 2017. The commissioner
429.23 of health shall convene the first meeting by November 15, 2017, and the commissioner or
429.24 the commissioner's designee shall act as chair until the council elects a chair at its first
429.25 meeting.

429.26 **Sec. 83. YOUTH SPORTS CONCUSSION WORKING GROUP.**

429.27 Subdivision 1. **Working group established; duties and membership.** (a) The
429.28 commissioner of health shall convene a youth sports concussion working group of up to 30
429.29 members to:

429.30 (1) develop the report described in subdivision 4 to assess the causes and incidence of
429.31 brain injury in Minnesota youth sports; and

430.1 (2) evaluate the implementation of Minnesota Statutes, sections 121A.37 and 121A.38,
430.2 regarding concussions in youth athletic activity, and best practices for preventing, identifying,
430.3 evaluating, and treating brain injury in youth sports.

430.4 (b) In forming the working group, the commissioner shall solicit nominees from
430.5 individuals with expertise and experience in the areas of traumatic brain injury in youth and
430.6 sports, neuroscience, law and policy related to brain health, public health, neurotrauma,
430.7 provision of care to brain injured youth, and related fields. In selecting members of the
430.8 working group, the commissioner shall ensure geographic and professional diversity. The
430.9 working group shall elect a chair from among its members. The commissioner shall be
430.10 responsible for organizing meetings and preparing a draft report. Members of the working
430.11 group shall not receive monetary compensation for their participation in the group.

430.12 Subd. 2. **Working group goals defined.** The working group shall, at a minimum:

430.13 (1) gather and analyze available data on:

430.14 (i) the prevalence and causes of youth sports-related concussions including, where
430.15 possible, data on the number of officials and coaches receiving concussion training;

430.16 (ii) the number of coaches, officials, youth athletes, and parents or guardians receiving
430.17 information about the nature and risks of concussions;

430.18 (iii) the number of youth athletes removed from play and the nature and duration of
430.19 treatment before return to play; and

430.20 (iv) policies and procedures related to return to learn in the classroom;

430.21 (2) review the rules associated with relevant youth athletic activities and the concussion
430.22 education policies currently employed;

430.23 (3) identify innovative pilot projects in areas such as:

430.24 (i) objectively defining and measuring concussions;

430.25 (ii) rule changes designed to promote brain health;

430.26 (iii) use of technology to identify and treat concussions;

430.27 (iv) recognition of cumulative subconcussive effects; and

430.28 (v) postconcussion treatment, and return to learn protocols; and

430.29 (4) identify regulatory and legal barriers and burdens to achieving better brain health
430.30 outcomes.

431.1 Subd. 3. **Voluntary participation; no new reporting requirements created.**

431.2 Participation in the working group study by schools, school districts, school governing
 431.3 bodies, parents, athletes, and related individuals and organizations shall be voluntary, and
 431.4 this study shall create no new reporting requirements by schools, school districts, school
 431.5 governing bodies, parents, athletes, and related individuals and organizations.

431.6 Subd. 4. **Report.** By December 31, 2018, the youth sports concussion working group
 431.7 shall provide an interim report, and by December 31, 2019, the working group shall provide
 431.8 a final report to the chairs and ranking minority members of the legislative committees with
 431.9 jurisdiction over health and education with recommendations and proposals for a Minnesota
 431.10 model for reducing brain injury in youth sports. The report shall make recommendations
 431.11 regarding:

431.12 (1) best practices for reducing and preventing concussions in youth sports;

431.13 (2) best practices for schools to employ in order to identify and respond to occurrences
 431.14 of concussions, including return to play and return to learn;

431.15 (3) opportunities to highlight and strengthen best practices with external grant support;

431.16 (4) opportunities to leverage Minnesota's strengths in brain science research and clinical
 431.17 care for brain injury; and

431.18 (5) proposals to develop an innovative Minnesota model for identifying, evaluating, and
 431.19 treating youth sports concussions.

431.20 Subd. 5. **Sunset.** The working group expires the day after submitting the report required
 431.21 under subdivision 4, or January 15, 2020, whichever is earlier.

431.22 Sec. 84. **REPEALER.**

431.23 (a) Minnesota Statutes 2016, section 144.4961, is repealed the day following final
 431.24 enactment.

431.25 (b) Laws 2014, chapter 312, article 23, section 9, subdivision 5, is repealed.

431.26 **ARTICLE 11**

431.27 **HEALTH LICENSING BOARDS**

431.28 Section 1. Minnesota Statutes 2016, section 147.01, subdivision 7, is amended to read:

431.29 Subd. 7. **Physician application fee and license fees.** (a) The board may charge a the
 431.30 following nonrefundable application and license fees processed pursuant to sections 147.02,
 431.31 147.03, 147.037, 147.0375, and 147.38:

- 432.1 (1) physician application fee of \$200;
 432.2 (2) physician annual registration renewal fee, \$192;
 432.3 (3) physician endorsement to other states, \$40;
 432.4 (4) physician emeritus license, \$50;
 432.5 (5) physician temporary licenses, \$60;
 432.6 (6) physician late fee, \$60;
 432.7 (7) duplicate license fee, \$20;
 432.8 (8) certification letter fee, \$25;
 432.9 (9) education or training program approval fee, \$100;
 432.10 (10) report creation and generation fee, \$60;
 432.11 (11) examination administration fee (half day), \$50;
 432.12 (12) examination administration fee (full day), \$80; and
 432.13 (13) fees developed by the Interstate Commission for determining physician qualification
 432.14 to register and participate in the interstate medical licensure compact, as established in rules
 432.15 authorized in and pursuant to section 147.38, not to exceed \$1,000.

432.16 (b) The board may prorate the initial annual license fee. All licensees are required to
 432.17 pay the full fee upon license renewal. The revenue generated from the fee must be deposited
 432.18 in an account in the state government special revenue fund.

432.19 Sec. 2. Minnesota Statutes 2016, section 147.02, subdivision 1, is amended to read:

432.20 Subdivision 1. **United States or Canadian medical school graduates.** The board shall
 432.21 issue a license to practice medicine to a person not currently licensed in another state or
 432.22 Canada and who meets the requirements in paragraphs (a) to (i).

432.23 (a) An applicant for a license shall file a written application on forms provided by the
 432.24 board, showing to the board's satisfaction that the applicant is of good moral character and
 432.25 satisfies the requirements of this section.

432.26 (b) The applicant shall present evidence satisfactory to the board of being a graduate of
 432.27 a medical or osteopathic medical school located in the United States, its territories or Canada,
 432.28 and approved by the board based upon its faculty, curriculum, facilities, accreditation by a
 432.29 recognized national accrediting organization approved by the board, and other relevant data,
 432.30 or is currently enrolled in the final year of study at the school.

433.1 (c) The applicant must have passed an examination as described in clause (1) or (2).

433.2 (1) The applicant must have passed a comprehensive examination for initial licensure
433.3 prepared and graded by the National Board of Medical Examiners, the Federation of State
433.4 Medical Boards, the Medical Council of Canada, the National Board of Osteopathic
433.5 Examiners, or the appropriate state board that the board determines acceptable. The board
433.6 shall by rule determine what constitutes a passing score in the examination.

433.7 (2) The applicant taking the United States Medical Licensing Examination (USMLE)
433.8 or Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) must
433.9 have passed steps or levels one, two, and three. Step or level three must be passed within
433.10 five years of passing step or level two, or before the end of residency training. The applicant
433.11 must pass each of steps or levels one, two, and three with passing scores as recommended
433.12 by the USMLE program or National Board of Osteopathic Medical Examiners within three
433.13 attempts. The applicant taking combinations of Federation of State Medical Boards, National
433.14 Board of Medical Examiners, and USMLE may be accepted only if the combination is
433.15 approved by the board as comparable to existing comparable examination sequences and
433.16 all examinations are completed prior to the year 2000.

433.17 (d) The applicant shall present evidence satisfactory to the board of the completion of
433.18 one year of graduate, clinical medical training in a program accredited by a national
433.19 accrediting organization approved by the board or other graduate training approved in
433.20 advance by the board as meeting standards similar to those of a national accrediting
433.21 organization.

433.22 (e) The applicant may make arrangements with the executive director to appear in person
433.23 before the board or its designated representative to show that the applicant satisfies the
433.24 requirements of this section. The board may establish as internal operating procedures the
433.25 procedures or requirements for the applicant's personal presentation.

433.26 (f) The applicant shall pay a nonrefundable fee established by the board ~~by rule. The~~
433.27 ~~fee may not be refunded.~~ Upon application or notice of license renewal, the board must
433.28 provide notice to the applicant and to the person whose license is scheduled to be issued or
433.29 renewed of any additional fees, surcharges, or other costs which the person is obligated to
433.30 pay as a condition of licensure. The notice must:

433.31 (1) state the dollar amount of the additional costs; and

433.32 (2) clearly identify to the applicant the payment schedule of additional costs.

434.1 (g) The applicant must not be under license suspension or revocation by the licensing
434.2 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
434.3 occurred.

434.4 (h) The applicant must not have engaged in conduct warranting disciplinary action
434.5 against a licensee, or have been subject to disciplinary action other than as specified in
434.6 paragraph (g). If the applicant does not satisfy the requirements stated in this paragraph,
434.7 the board may issue a license only on the applicant's showing that the public will be protected
434.8 through issuance of a license with conditions and limitations the board considers appropriate.

434.9 (i) If the examination in paragraph (c) was passed more than ten years ago, the applicant
434.10 must either:

434.11 (1) pass the special purpose examination of the Federation of State Medical Boards with
434.12 a score of 75 or better within three attempts; or

434.13 (2) have a current certification by a specialty board of the American Board of Medical
434.14 Specialties, of the American Osteopathic Association, the Royal College of Physicians and
434.15 Surgeons of Canada, or of the College of Family Physicians of Canada.

434.16 Sec. 3. Minnesota Statutes 2016, section 147.03, subdivision 1, is amended to read:

434.17 Subdivision 1. **Endorsement; reciprocity.** (a) The board may issue a license to practice
434.18 medicine to any person who satisfies the requirements in paragraphs (b) to ~~(f)~~(e).

434.19 (b) The applicant shall satisfy all the requirements established in section 147.02,
434.20 subdivision 1, paragraphs (a), (b), (d), (e), and (f).

434.21 (c) The applicant shall:

434.22 (1) have passed an examination prepared and graded by the Federation of State Medical
434.23 Boards, the National Board of Medical Examiners, or the United States Medical Licensing
434.24 Examination (USMLE) program in accordance with section 147.02, subdivision 1, paragraph
434.25 (c), clause (2); the National Board of Osteopathic Medical Examiners; or the Medical Council
434.26 of Canada; and

434.27 (2) have a current license from the equivalent licensing agency in another state or Canada
434.28 and, if the examination in clause (1) was passed more than ten years ago, either:

434.29 (i) pass the Special Purpose Examination of the Federation of State Medical Boards with
434.30 a score of 75 or better within three attempts; or

435.1 (ii) have a current certification by a specialty board of the American Board of Medical
 435.2 Specialties, of the American Osteopathic Association, the Royal College of Physicians and
 435.3 Surgeons of Canada, or of the College of Family Physicians of Canada; or

435.4 (3) if the applicant fails to meet the requirement established in section 147.02, subdivision
 435.5 1, paragraph (c), clause (2), because the applicant failed to pass each of steps one, two, and
 435.6 three of the USMLE within the required three attempts, the applicant may be granted a
 435.7 license provided the applicant:

435.8 (i) has passed each of steps one, two, and three with passing scores as recommended by
 435.9 the USMLE program within no more than four attempts for any of the three steps;

435.10 (ii) is currently licensed in another state; and

435.11 (iii) has current certification by a specialty board of the American Board of Medical
 435.12 Specialties, the American Osteopathic Association Bureau of Professional Education, the
 435.13 Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians
 435.14 of Canada.

435.15 ~~(d) The applicant shall pay a fee established by the board by rule. The fee may not be~~
 435.16 ~~refunded.~~

435.17 ~~(e)~~ (d) The applicant must not be under license suspension or revocation by the licensing
 435.18 board of the state or jurisdiction in which the conduct that caused the suspension or revocation
 435.19 occurred.

435.20 ~~(f)~~ (e) The applicant must not have engaged in conduct warranting disciplinary action
 435.21 against a licensee, or have been subject to disciplinary action other than as specified in
 435.22 paragraph ~~(e)~~ (d). If an applicant does not satisfy the requirements stated in this paragraph,
 435.23 the board may issue a license only on the applicant's showing that the public will be protected
 435.24 through issuance of a license with conditions or limitations the board considers appropriate.

435.25 ~~(g)~~ (f) Upon the request of an applicant, the board may conduct the final interview of
 435.26 the applicant by teleconference.

435.27 Sec. 4. **[147A.28] PHYSICIAN ASSISTANT APPLICATION AND LICENSE FEES.**

435.28 (a) The board may charge the following nonrefundable fees:

435.29 (1) physician assistant application fee, \$120;

435.30 (2) physician assistant annual registration renewal fee (prescribing authority), \$135;

435.31 (3) physician assistant annual registration renewal fee (no prescribing authority), \$115;

- 436.1 (4) physician assistant temporary registration, \$115;
436.2 (5) physician assistant temporary permit, \$60;
436.3 (6) physician assistant locum tenens permit, \$25;
436.4 (7) physician assistant late fee, \$50;
436.5 (8) duplicate license fee, \$20;
436.6 (9) certification letter fee, \$25;
436.7 (10) education or training program approval fee, \$100; and
436.8 (11) report creation and generation fee, \$60.
- 436.9 (b) The board may prorate the initial annual license fee. All licensees are required to
436.10 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
436.11 in an account in the state government special revenue fund.

436.12 Sec. 5. Minnesota Statutes 2016, section 147B.08, is amended by adding a subdivision to
436.13 read:

436.14 Subd. 4. **Acupuncturist application and license fees.** (a) The board may charge the
436.15 following nonrefundable fees:

- 436.16 (1) acupuncturist application fee, \$150;
436.17 (2) acupuncturist annual registration renewal fee, \$150;
436.18 (3) acupuncturist temporary registration fee, \$60;
436.19 (4) acupuncturist inactive status fee, \$50;
436.20 (5) acupuncturist late fee, \$50;
436.21 (6) duplicate license fee, \$20;
436.22 (7) certification letter fee, \$25;
436.23 (8) education or training program approval fee, \$100; and
436.24 (9) report creation and generation fee, \$60.
- 436.25 (b) The board may prorate the initial annual license fee. All licensees are required to
436.26 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
436.27 in an account in the state government special revenue fund.

437.1 Sec. 6. Minnesota Statutes 2016, section 147C.40, is amended by adding a subdivision to
437.2 read:

437.3 Subd. 5. **Respiratory therapist application and license fees.** (a) The board may charge
437.4 the following nonrefundable fees:

437.5 (1) respiratory therapist application fee, \$100;

437.6 (2) respiratory therapist annual registration renewal fee, \$90;

437.7 (3) respiratory therapist inactive status fee, \$50;

437.8 (4) respiratory therapist temporary registration fee, \$90;

437.9 (5) respiratory therapist temporary permit, \$60;

437.10 (6) respiratory therapist late fee, \$50;

437.11 (7) duplicate license fee, \$20;

437.12 (8) certification letter fee, \$25;

437.13 (9) education or training program approval fee, \$100; and

437.14 (10) report creation and generation fee, \$60.

437.15 (b) The board may prorate the initial annual license fee. All licensees are required to
437.16 pay the full fee upon license renewal. The revenue generated from the fees must be deposited
437.17 in an account in the state government special revenue fund.

437.18 Sec. 7. Minnesota Statutes 2016, section 148.6402, subdivision 4, is amended to read:

437.19 Subd. 4. ~~Commissioner Board.~~ "Commissioner Board" means the ~~commissioner of~~
437.20 ~~health or a designee~~ Board of Occupational Therapy Practice established in section 148.6449.

437.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

437.22 Sec. 8. Minnesota Statutes 2016, section 148.6405, is amended to read:

437.23 **148.6405 LICENSURE APPLICATION REQUIREMENTS: PROCEDURES AND**
437.24 **QUALIFICATIONS.**

437.25 (a) An applicant for licensure must comply with the application requirements in section
437.26 148.6420. To qualify for licensure, an applicant must satisfy one of the requirements in
437.27 paragraphs (b) to (f) and not be subject to denial of licensure under section 148.6448.

438.1 (b) A person who applies for licensure as an occupational therapist and who has not
438.2 been credentialed by the National Board for Certification in Occupational Therapy or another
438.3 jurisdiction must meet the requirements in section 148.6408.

438.4 (c) A person who applies for licensure as an occupational therapy assistant and who has
438.5 not been credentialed by the National Board for Certification in Occupational Therapy or
438.6 another jurisdiction must meet the requirements in section 148.6410.

438.7 (d) A person who is certified by the National Board for Certification in Occupational
438.8 Therapy may apply for licensure by equivalency and must meet the requirements in section
438.9 148.6412.

438.10 (e) A person who is credentialed in another jurisdiction may apply for licensure by
438.11 reciprocity and must meet the requirements in section 148.6415.

438.12 (f) A person who applies for temporary licensure must meet the requirements in section
438.13 148.6418.

438.14 (g) A person who applies for licensure under paragraph (b), (c), or (f) more than two
438.15 and less than four years after meeting the requirements in section 148.6408 or 148.6410
438.16 must submit the following:

438.17 (1) a completed and signed application for licensure on forms provided by the
438.18 ~~commissioner~~ board;

438.19 (2) the license application fee required under section 148.6445;

438.20 (3) if applying for occupational therapist licensure, proof of having met a minimum of
438.21 24 contact hours of continuing education in the two years preceding licensure application,
438.22 or if applying for occupational therapy assistant licensure, proof of having met a minimum
438.23 of 18 contact hours of continuing education in the two years preceding licensure application;

438.24 (4) verified documentation of successful completion of 160 hours of supervised practice
438.25 approved by the ~~commissioner~~ board under a limited license specified in section 148.6425,
438.26 subdivision 3, paragraph (c); and

438.27 (5) additional information as requested by the ~~commissioner~~ board to clarify information
438.28 in the application, including information to determine whether the individual has engaged
438.29 in conduct warranting disciplinary action under section 148.6448. The information must be
438.30 submitted within 30 days after the ~~commissioner's~~ board's request.

438.31 (h) A person who applied for licensure under paragraph (b), (c), or (f) four years or more
438.32 after meeting the requirements in section 148.6408 or 148.6410 must meet all the

439.1 requirements in paragraph (g) except clauses (3) and (4), submit documentation of having
439.2 retaken and passed the credentialing examination for occupational therapist or occupational
439.3 therapy assistant, or of having completed an occupational therapy refresher program that
439.4 contains both a theoretical and clinical component approved by the ~~commissioner~~ board,
439.5 and verified documentation of successful completion of 480 hours of supervised practice
439.6 approved by the ~~commissioner~~ board under a limited license specified in section 148.6425,
439.7 subdivision 3, paragraph (c). The 480 hours of supervised practice must be completed in
439.8 six months and may be completed at the applicant's place of work. Only refresher courses
439.9 completed within one year prior to the date of application qualify for approval.

439.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

439.11 Sec. 9. Minnesota Statutes 2016, section 148.6408, subdivision 2, is amended to read:

439.12 Subd. 2. **Qualifying examination score required.** (a) An applicant must achieve a
439.13 qualifying score on the credentialing examination for occupational therapist.

439.14 (b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing
439.15 examination for occupational therapist. In determining the qualifying score, the ~~commissioner~~
439.16 board shall consider the cut score recommended by the National Board for Certification in
439.17 Occupational Therapy, or other national credentialing organization approved by the
439.18 ~~commissioner~~ board, using the modified Angoff method for determining cut score or another
439.19 method for determining cut score that is recognized as appropriate and acceptable by industry
439.20 standards.

439.21 (c) The applicant is responsible for:

439.22 (1) making arrangements to take the credentialing examination for occupational therapist;

439.23 (2) bearing all expenses associated with taking the examination; and

439.24 (3) having the examination scores sent directly to the ~~commissioner~~ board from the
439.25 testing service that administers the examination.

439.26 **EFFECTIVE DATE.** This section is effective January 1, 2018.

439.27 Sec. 10. Minnesota Statutes 2016, section 148.6410, subdivision 2, is amended to read:

439.28 Subd. 2. **Qualifying examination score required.** (a) An applicant for licensure must
439.29 achieve a qualifying score on the credentialing examination for occupational therapy
439.30 assistants.

440.1 (b) The ~~commissioner~~ board shall determine the qualifying score for the credentialing
440.2 examination for occupational therapy assistants. In determining the qualifying score, the
440.3 ~~commissioner~~ board shall consider the cut score recommended by the National Board for
440.4 Certification in Occupational Therapy, or other national credentialing organization approved
440.5 by the ~~commissioner~~ board, using the modified Angoff method for determining cut score
440.6 or another method for determining cut score that is recognized as appropriate and acceptable
440.7 by industry standards.

440.8 (c) The applicant is responsible for:

440.9 (1) making all arrangements to take the credentialing examination for occupational
440.10 therapy assistants;

440.11 (2) bearing all expense associated with taking the examination; and

440.12 (3) having the examination scores sent directly to the ~~commissioner~~ board from the
440.13 testing service that administers the examination.

440.14 **EFFECTIVE DATE.** This section is effective January 1, 2018.

440.15 Sec. 11. Minnesota Statutes 2016, section 148.6412, subdivision 2, is amended to read:

440.16 Subd. 2. **Persons certified by National Board for Certification in Occupational**
440.17 **Therapy after June 17, 1996.** The ~~commissioner~~ board may license any person certified
440.18 by the National Board for Certification in Occupational Therapy as an occupational therapist
440.19 after June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification
440.20 are equivalent to or exceed the requirements for licensure as an occupational therapist under
440.21 section 148.6408. The ~~commissioner~~ board may license any person certified by the National
440.22 Board for Certification in Occupational Therapy as an occupational therapy assistant after
440.23 June 17, 1996, if the ~~commissioner~~ board determines the requirements for certification are
440.24 equivalent to or exceed the requirements for licensure as an occupational therapy assistant
440.25 under section 148.6410. Nothing in this section limits the ~~commissioner's~~ board's authority
440.26 to deny licensure based upon the grounds for discipline in sections 148.6401 to ~~148.6450~~
440.27 148.6449.

440.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

440.29 Sec. 12. Minnesota Statutes 2016, section 148.6415, is amended to read:

440.30 **148.6415 LICENSURE BY RECIPROCITY.**

441.1 A person who holds a current credential as an occupational therapist in the District of
 441.2 Columbia or a state or territory of the United States whose standards for credentialing are
 441.3 determined by the ~~commissioner~~ board to be equivalent to or exceed the requirements for
 441.4 licensure under section 148.6408 may be eligible for licensure by reciprocity as an
 441.5 occupational therapist. A person who holds a current credential as an occupational therapy
 441.6 assistant in the District of Columbia or a state or territory of the United States whose
 441.7 standards for credentialing are determined by the ~~commissioner~~ board to be equivalent to
 441.8 or exceed the requirements for licensure under section 148.6410 may be eligible for licensure
 441.9 by reciprocity as an occupational therapy assistant. Nothing in this section limits the
 441.10 ~~commissioner's~~ board's authority to deny licensure based upon the grounds for discipline
 441.11 in sections 148.6401 to ~~148.6450~~ 148.6449. An applicant must provide:

441.12 (1) the application materials as required by section 148.6420, subdivisions 1, 3, and 4;

441.13 (2) the fees required by section 148.6445;

441.14 (3) a copy of a current and unrestricted credential for the practice of occupational therapy
 441.15 as either an occupational therapist or occupational therapy assistant;

441.16 (4) a letter from the jurisdiction that issued the credential describing the applicant's
 441.17 qualifications that entitled the applicant to receive the credential; and

441.18 (5) other information necessary to determine whether the credentialing standards of the
 441.19 jurisdiction that issued the credential are equivalent to or exceed the requirements for
 441.20 licensure under sections 148.6401 to ~~148.6450~~ 148.6449.

441.21 **EFFECTIVE DATE.** This section is effective January 1, 2018.

441.22 Sec. 13. Minnesota Statutes 2016, section 148.6418, subdivision 1, is amended to read:

441.23 Subdivision 1. **Application.** The ~~commissioner~~ board shall issue temporary licensure
 441.24 as an occupational therapist or occupational therapy assistant to applicants who are not the
 441.25 subject of a disciplinary action or past disciplinary action, nor disqualified on the basis of
 441.26 items listed in section 148.6448, subdivision 1.

441.27 **EFFECTIVE DATE.** This section is effective January 1, 2018.

441.28 Sec. 14. Minnesota Statutes 2016, section 148.6418, subdivision 2, is amended to read:

441.29 Subd. 2. **Procedures.** To be eligible for temporary licensure, an applicant must submit
 441.30 a completed application for temporary licensure on forms provided by the ~~commissioner~~
 441.31 board, the fees required by section 148.6445, and one of the following:

442.1 (1) evidence of successful completion of the requirements in section 148.6408,
442.2 subdivision 1, or 148.6410, subdivision 1;

442.3 (2) a copy of a current and unrestricted credential for the practice of occupational therapy
442.4 as either an occupational therapist or occupational therapy assistant in another jurisdiction;
442.5 or

442.6 (3) a copy of a current and unrestricted certificate from the National Board for
442.7 Certification in Occupational Therapy stating that the applicant is certified as an occupational
442.8 therapist or occupational therapy assistant.

442.9 **EFFECTIVE DATE.** This section is effective January 1, 2018.

442.10 Sec. 15. Minnesota Statutes 2016, section 148.6418, subdivision 4, is amended to read:

442.11 Subd. 4. **Supervision required.** An applicant who has graduated from an accredited
442.12 occupational therapy program, as required by section 148.6408, subdivision 1, or 148.6410,
442.13 subdivision 1, and who has not passed the examination required by section 148.6408,
442.14 subdivision 2, or 148.6410, subdivision 2, must practice under the supervision of a licensed
442.15 occupational therapist. The supervising therapist must, at a minimum, supervise the person
442.16 working under temporary licensure in the performance of the initial evaluation, determination
442.17 of the appropriate treatment plan, and periodic review and modification of the treatment
442.18 plan. The supervising therapist must observe the person working under temporary licensure
442.19 in order to assure service competency in carrying out evaluation, treatment planning, and
442.20 treatment implementation. The frequency of face-to-face collaboration between the person
442.21 working under temporary licensure and the supervising therapist must be based on the
442.22 condition of each patient or client, the complexity of treatment and evaluation procedures,
442.23 and the proficiencies of the person practicing under temporary licensure. The occupational
442.24 therapist or occupational therapy assistant working under temporary licensure must provide
442.25 verification of supervision on the application form provided by the ~~commissioner~~ board.

442.26 **EFFECTIVE DATE.** This section is effective January 1, 2018.

442.27 Sec. 16. Minnesota Statutes 2016, section 148.6418, subdivision 5, is amended to read:

442.28 Subd. 5. **Expiration of temporary licensure.** A temporary license issued to a person
442.29 pursuant to subdivision 2, clause (1), expires six months from the date of issuance for
442.30 occupational therapists and occupational therapy assistants or on the date the ~~commissioner~~
442.31 board grants or denies licensure, whichever occurs first. A temporary license issued to a
442.32 person pursuant to subdivision 2, clause (2) or (3), expires 90 days after it is issued. Upon

443.1 application for renewal, a temporary license shall be renewed once to persons who have
443.2 not met the examination requirement under section 148.6408, subdivision 2, or 148.6410,
443.3 subdivision 2, within the initial temporary licensure period and who are not the subject of
443.4 a disciplinary action nor disqualified on the basis of items in section 148.6448, subdivision
443.5 1. Upon application for renewal, a temporary license shall be renewed once to persons who
443.6 are able to demonstrate good cause for failure to meet the requirements for licensure under
443.7 section 148.6412 or 148.6415 within the initial temporary licensure period and who are not
443.8 the subject of a disciplinary action nor disqualified on the basis of items in section 148.6448,
443.9 subdivision 1.

443.10 **EFFECTIVE DATE.** This section is effective January 1, 2018.

443.11 Sec. 17. Minnesota Statutes 2016, section 148.6420, subdivision 1, is amended to read:

443.12 Subdivision 1. **Applications for licensure.** An applicant for licensure must:

443.13 (1) submit a completed application for licensure on forms provided by the ~~commissioner~~
443.14 board and must supply the information requested on the application, including:

443.15 (i) the applicant's name, business address and business telephone number, business
443.16 setting, and daytime telephone number;

443.17 (ii) the name and location of the occupational therapy program the applicant completed;

443.18 (iii) a description of the applicant's education and training, including a list of degrees
443.19 received from educational institutions;

443.20 (iv) the applicant's work history for the six years preceding the application, including
443.21 the number of hours worked;

443.22 (v) a list of all credentials currently and previously held in Minnesota and other
443.23 jurisdictions;

443.24 (vi) a description of any jurisdiction's refusal to credential the applicant;

443.25 (vii) a description of all professional disciplinary actions initiated against the applicant
443.26 in any jurisdiction;

443.27 (viii) information on any physical or mental condition or chemical dependency that
443.28 impairs the person's ability to engage in the practice of occupational therapy with reasonable
443.29 judgment or safety;

443.30 (ix) a description of any misdemeanor or felony conviction that relates to honesty or to
443.31 the practice of occupational therapy;

444.1 (x) a description of any state or federal court order, including a conciliation court
 444.2 judgment or a disciplinary order, related to the individual's occupational therapy practice;
 444.3 and

444.4 (xi) a statement indicating the physical agent modalities the applicant will use and
 444.5 whether the applicant will use the modalities as an occupational therapist or an occupational
 444.6 therapy assistant under direct supervision;

444.7 (2) submit with the application all fees required by section 148.6445;

444.8 (3) sign a statement that the information in the application is true and correct to the best
 444.9 of the applicant's knowledge and belief;

444.10 (4) sign a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's
 444.11 records in this or any other state in which the applicant holds or previously held a credential
 444.12 for the practice of an occupation, has completed an accredited occupational therapy education
 444.13 program, or engaged in the practice of occupational therapy;

444.14 (5) submit additional information as requested by the ~~commissioner~~ board; and

444.15 (6) submit the additional information required for licensure by equivalency, licensure
 444.16 by reciprocity, and temporary licensure as specified in sections 148.6408 to 148.6418.

444.17 **EFFECTIVE DATE.** This section is effective January 1, 2018.

444.18 Sec. 18. Minnesota Statutes 2016, section 148.6420, subdivision 3, is amended to read:

444.19 Subd. 3. **Applicants certified by National Board for Certification in Occupational**
 444.20 **Therapy.** An applicant who is certified by the National Board for Certification in
 444.21 Occupational Therapy must provide the materials required in subdivision 1 and the following:

444.22 (1) verified documentation from the National Board for Certification in Occupational
 444.23 Therapy stating that the applicant is certified as an occupational therapist, registered or
 444.24 certified occupational therapy assistant, the date certification was granted, and the applicant's
 444.25 certification number. The document must also include a statement regarding disciplinary
 444.26 actions. The applicant is responsible for obtaining this documentation by sending a form
 444.27 provided by the ~~commissioner~~ board to the National Board for Certification in Occupational
 444.28 Therapy; and

444.29 (2) a waiver authorizing the ~~commissioner~~ board to obtain access to the applicant's
 444.30 records maintained by the National Board for Certification in Occupational Therapy.

444.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

445.1 Sec. 19. Minnesota Statutes 2016, section 148.6420, subdivision 5, is amended to read:

445.2 Subd. 5. **Action on applications for licensure.** (a) The ~~commissioner~~ board shall
445.3 approve, approve with conditions, or deny licensure. The ~~commissioner~~ board shall act on
445.4 an application for licensure according to paragraphs (b) to (d).

445.5 (b) The ~~commissioner~~ board shall determine if the applicant meets the requirements for
445.6 licensure. The ~~commissioner~~ board, or the advisory council at the ~~commissioner's~~ board's
445.7 request, may investigate information provided by an applicant to determine whether the
445.8 information is accurate and complete.

445.9 (c) The ~~commissioner~~ board shall notify an applicant of action taken on the application
445.10 and, if licensure is denied or approved with conditions, the grounds for the ~~commissioner's~~
445.11 board's determination.

445.12 (d) An applicant denied licensure or granted licensure with conditions may make a
445.13 written request to the ~~commissioner~~ board, within 30 days of the date of the ~~commissioner's~~
445.14 board's determination, for reconsideration of the ~~commissioner's~~ board's determination.
445.15 Individuals requesting reconsideration may submit information which the applicant wants
445.16 considered in the reconsideration. After reconsideration of the ~~commissioner's~~ board's
445.17 determination to deny licensure or grant licensure with conditions, the ~~commissioner~~ board
445.18 shall determine whether the original determination should be affirmed or modified. An
445.19 applicant is allowed no more than one request in any one biennial licensure period for
445.20 reconsideration of the ~~commissioner's~~ board's determination to deny licensure or approve
445.21 licensure with conditions.

445.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

445.23 Sec. 20. Minnesota Statutes 2016, section 148.6423, is amended to read:

445.24 **148.6423 LICENSURE RENEWAL.**

445.25 Subdivision 1. **Renewal requirements.** To be eligible for licensure renewal, a licensee
445.26 must:

445.27 (1) submit a completed and signed application for licensure renewal on forms provided
445.28 by the ~~commissioner~~ board;

445.29 (2) submit the renewal fee required under section 148.6445;

445.30 (3) submit proof of having met the continuing education requirement of section 148.6443
445.31 on forms provided by the ~~commissioner~~ board; and

446.1 (4) submit additional information as requested by the ~~commissioner~~ board to clarify
446.2 information presented in the renewal application. The information must be submitted within
446.3 30 days after the ~~commissioner's~~ board's request.

446.4 Subd. 2. **Renewal deadline.** (a) Except as provided in paragraph (c), licenses must be
446.5 renewed every two years. Licensees must comply with the following procedures in paragraphs
446.6 (b) to (e):

446.7 (b) Each license must state an expiration date. An application for licensure renewal must
446.8 be received by the ~~Department of Health~~ board or postmarked at least 30 calendar days
446.9 before the expiration date. If the postmark is illegible, the application shall be considered
446.10 timely if received at least 21 calendar days before the expiration date.

446.11 (c) If the ~~commissioner~~ board changes the renewal schedule and the expiration date is
446.12 less than two years, the fee and the continuing education contact hours to be reported at the
446.13 next renewal must be prorated.

446.14 (d) An application for licensure renewal not received within the time required under
446.15 paragraph (b), but received on or before the expiration date, must be accompanied by a late
446.16 fee in addition to the renewal fee specified by section 148.6445.

446.17 (e) Licensure renewals received after the expiration date shall not be accepted and persons
446.18 seeking licensed status must comply with the requirements of section 148.6425.

446.19 Subd. 3. **Licensure renewal notice.** At least 60 calendar days before the expiration date
446.20 in subdivision 2, the ~~commissioner~~ board shall mail a renewal notice to the licensee's last
446.21 known address on file with the ~~commissioner~~ board. The notice must include an application
446.22 for licensure renewal and notice of fees required for renewal. The licensee's failure to receive
446.23 notice does not relieve the licensee of the obligation to meet the renewal deadline and other
446.24 requirements for licensure renewal.

446.25 **EFFECTIVE DATE.** This section is effective January 1, 2018.

446.26 Sec. 21. Minnesota Statutes 2016, section 148.6425, subdivision 2, is amended to read:

446.27 Subd. 2. **Licensure renewal after licensure expiration date.** An individual whose
446.28 application for licensure renewal is received after the licensure expiration date must submit
446.29 the following:

446.30 (1) a completed and signed application for licensure following lapse in licensed status
446.31 on forms provided by the ~~commissioner~~ board;

446.32 (2) the renewal fee and the late fee required under section 148.6445;

447.1 (3) proof of having met the continuing education requirements in section 148.6443,
447.2 subdivision 1; and

447.3 (4) additional information as requested by the ~~commissioner~~ board to clarify information
447.4 in the application, including information to determine whether the individual has engaged
447.5 in conduct warranting disciplinary action as set forth in section 148.6448. The information
447.6 must be submitted within 30 days after the ~~commissioner's~~ board's request.

447.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

447.8 Sec. 22. Minnesota Statutes 2016, section 148.6425, subdivision 3, is amended to read:

447.9 Subd. 3. **Licensure renewal four years or more after licensure expiration date.** (a)
447.10 An individual who requests licensure renewal four years or more after the licensure expiration
447.11 date must submit the following:

447.12 (1) a completed and signed application for licensure on forms provided by the
447.13 ~~commissioner~~ board;

447.14 (2) the renewal fee and the late fee required under section 148.6445 if renewal application
447.15 is based on paragraph (b), clause (1), (2), or (3), or the renewal fee required under section
447.16 148.6445 if renewal application is based on paragraph (b), clause (4);

447.17 (3) proof of having met the continuing education requirement in section 148.6443,
447.18 subdivision 1, except the continuing education must be obtained in the two years immediately
447.19 preceding application renewal; and

447.20 (4) at the time of the next licensure renewal, proof of having met the continuing education
447.21 requirement, which shall be prorated based on the number of months licensed during the
447.22 two-year licensure period.

447.23 (b) In addition to the requirements in paragraph (a), the applicant must submit proof of
447.24 one of the following:

447.25 (1) verified documentation of successful completion of 160 hours of supervised practice
447.26 approved by the ~~commissioner~~ board as described in paragraph (c);

447.27 (2) verified documentation of having achieved a qualifying score on the credentialing
447.28 examination for occupational therapists or the credentialing examination for occupational
447.29 therapy assistants administered within the past year;

447.30 (3) documentation of having completed a combination of occupational therapy courses
447.31 or an occupational therapy refresher program that contains both a theoretical and clinical
447.32 component approved by the ~~commissioner~~ board. Only courses completed within one year

448.1 preceding the date of the application or one year after the date of the application qualify for
448.2 approval; or

448.3 (4) evidence that the applicant holds a current and unrestricted credential for the practice
448.4 of occupational therapy in another jurisdiction and that the applicant's credential from that
448.5 jurisdiction has been held in good standing during the period of lapse.

448.6 (c) To participate in a supervised practice as described in paragraph (b), clause (1), the
448.7 applicant shall obtain limited licensure. To apply for limited licensure, the applicant shall
448.8 submit the completed limited licensure application, fees, and agreement for supervision of
448.9 an occupational therapist or occupational therapy assistant practicing under limited licensure
448.10 signed by the supervising therapist and the applicant. The supervising occupational therapist
448.11 shall state the proposed level of supervision on the supervision agreement form provided
448.12 by the ~~commissioner~~ board. The supervising therapist shall determine the frequency and
448.13 manner of supervision based on the condition of the patient or client, the complexity of the
448.14 procedure, and the proficiencies of the supervised occupational therapist. At a minimum, a
448.15 supervising occupational therapist shall be on the premises at all times that the person
448.16 practicing under limited licensure is working; be in the room ten percent of the hours worked
448.17 each week by the person practicing under limited licensure; and provide daily face-to-face
448.18 collaboration for the purpose of observing service competency of the occupational therapist
448.19 or occupational therapy assistant, discussing treatment procedures and each client's response
448.20 to treatment, and reviewing and modifying, as necessary, each treatment plan. The supervising
448.21 therapist shall document the supervision provided. The occupational therapist participating
448.22 in a supervised practice is responsible for obtaining the supervision required under this
448.23 paragraph and must comply with the ~~commissioner's~~ board's requirements for supervision
448.24 during the entire 160 hours of supervised practice. The supervised practice must be completed
448.25 in two months and may be completed at the applicant's place of work.

448.26 (d) In addition to the requirements in paragraphs (a) and (b), the applicant must submit
448.27 additional information as requested by the ~~commissioner~~ board to clarify information in the
448.28 application, including information to determine whether the applicant has engaged in conduct
448.29 warranting disciplinary action as set forth in section 148.6448. The information must be
448.30 submitted within 30 days after the ~~commissioner's~~ board's request.

448.31 **EFFECTIVE DATE.** This section is effective January 1, 2018.

448.32 Sec. 23. Minnesota Statutes 2016, section 148.6428, is amended to read:

448.33 **148.6428 CHANGE OF NAME, ADDRESS, OR EMPLOYMENT.**

449.1 A licensee who changes a name, address, or employment must inform the ~~commissioner~~
449.2 board, in writing, of the change of name, address, employment, business address, or business
449.3 telephone number within 30 days. A change in name must be accompanied by a copy of a
449.4 marriage certificate or court order. All notices or other correspondence mailed to or served
449.5 on a licensee by the ~~commissioner~~ board at the licensee's address on file with the
449.6 ~~commissioner~~ board shall be considered as having been received by the licensee.

449.7 **EFFECTIVE DATE.** This section is effective January 1, 2018.

449.8 Sec. 24. Minnesota Statutes 2016, section 148.6443, subdivision 5, is amended to read:

449.9 Subd. 5. **Reporting continuing education contact hours.** Within one month following
449.10 licensure expiration, each licensee shall submit verification that the licensee has met the
449.11 continuing education requirements of this section on the continuing education report form
449.12 provided by the ~~commissioner~~ board. The continuing education report form may require
449.13 the following information:

449.14 (1) title of continuing education activity;

449.15 (2) brief description of the continuing education activity;

449.16 (3) sponsor, presenter, or author;

449.17 (4) location and attendance dates;

449.18 (5) number of contact hours; and

449.19 (6) licensee's notarized affirmation that the information is true and correct.

449.20 **EFFECTIVE DATE.** This section is effective January 1, 2018.

449.21 Sec. 25. Minnesota Statutes 2016, section 148.6443, subdivision 6, is amended to read:

449.22 Subd. 6. **Auditing continuing education reports.** (a) The ~~commissioner~~ board may
449.23 audit a percentage of the continuing education reports based on random selection. A licensee
449.24 shall maintain all documentation required by this section for two years after the last day of
449.25 the biennial licensure period in which the contact hours were earned.

449.26 (b) All renewal applications that are received after the expiration date may be subject
449.27 to a continuing education report audit.

449.28 (c) Any licensee against whom a complaint is filed may be subject to a continuing
449.29 education report audit.

450.1 (d) The licensee shall make the following information available to the ~~commissioner~~
450.2 board for auditing purposes:

450.3 (1) a copy of the completed continuing education report form for the continuing education
450.4 reporting period that is the subject of the audit including all supporting documentation
450.5 required by subdivision 5;

450.6 (2) a description of the continuing education activity prepared by the presenter or sponsor
450.7 that includes the course title or subject matter, date, place, number of program contact hours,
450.8 presenters, and sponsors;

450.9 (3) documentation of self-study programs by materials prepared by the presenter or
450.10 sponsor that includes the course title, course description, name of sponsor or author, and
450.11 the number of hours required to complete the program;

450.12 (4) documentation of university, college, or vocational school courses by a course
450.13 syllabus, listing in a course bulletin, or equivalent documentation that includes the course
450.14 title, instructor's name, course dates, number of contact hours, and course content, objectives,
450.15 or goals; and

450.16 (5) verification of attendance by:

450.17 (i) a signature of the presenter or a designee at the continuing education activity on the
450.18 continuing education report form or a certificate of attendance with the course name, course
450.19 date, and licensee's name;

450.20 (ii) a summary or outline of the educational content of an audio or video educational
450.21 activity to verify the licensee's participation in the activity if a designee is not available to
450.22 sign the continuing education report form;

450.23 (iii) verification of self-study programs by a certificate of completion or other
450.24 documentation indicating that the individual has demonstrated knowledge and has
450.25 successfully completed the program; or

450.26 (iv) verification of attendance at a university, college, or vocational course by an official
450.27 transcript.

450.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

450.29 Sec. 26. Minnesota Statutes 2016, section 148.6443, subdivision 7, is amended to read:

450.30 Subd. 7. **Waiver of continuing education requirements.** The ~~commissioner~~ board may
450.31 grant a waiver of the requirements of this section in cases where the requirements would
450.32 impose an extreme hardship on the licensee. The request for a waiver must be in writing,

451.1 state the circumstances that constitute extreme hardship, state the period of time the licensee
 451.2 wishes to have the continuing education requirement waived, and state the alternative
 451.3 measures that will be taken if a waiver is granted. The ~~commissioner~~ board shall set forth,
 451.4 in writing, the reasons for granting or denying the waiver. Waivers granted by the
 451.5 ~~commissioner~~ board shall specify, in writing, the time limitation and required alternative
 451.6 measures to be taken by the licensee. A request for waiver shall be denied if the ~~commissioner~~
 451.7 board finds that the circumstances stated by the licensee do not support a claim of extreme
 451.8 hardship, the requested time period for waiver is unreasonable, the alternative measures
 451.9 proposed by the licensee are not equivalent to the continuing education activity being waived,
 451.10 or the request for waiver is not submitted to the ~~commissioner~~ board within 60 days after
 451.11 the expiration date.

451.12 **EFFECTIVE DATE.** This section is effective January 1, 2018.

451.13 Sec. 27. Minnesota Statutes 2016, section 148.6443, subdivision 8, is amended to read:

451.14 Subd. 8. **Penalties for noncompliance.** The ~~commissioner~~ board shall refuse to renew
 451.15 or grant, or shall suspend, condition, limit, or qualify the license of any person who the
 451.16 ~~commissioner~~ board determines has failed to comply with the continuing education
 451.17 requirements of this section. A licensee may request reconsideration of the ~~commissioner's~~
 451.18 board's determination of noncompliance or the penalty imposed under this section by making
 451.19 a written request to the ~~commissioner~~ board within 30 days of the date of notification to the
 451.20 applicant. Individuals requesting reconsideration may submit information that the licensee
 451.21 wants considered in the reconsideration.

451.22 **EFFECTIVE DATE.** This section is effective January 1, 2018.

451.23 Sec. 28. Minnesota Statutes 2016, section 148.6445, subdivision 1, is amended to read:

451.24 Subdivision 1. **Initial licensure fee.** The initial licensure fee for occupational therapists
 451.25 is \$145. The initial licensure fee for occupational therapy assistants is \$80. The ~~commissioner~~
 451.26 board shall prorate fees based on the number of quarters remaining in the biennial licensure
 451.27 period.

451.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

451.29 Sec. 29. Minnesota Statutes 2016, section 148.6445, subdivision 10, is amended to read:

451.30 Subd. 10. **Use of fees.** All fees are nonrefundable. The ~~commissioner~~ board shall only
 451.31 use fees collected under this section for the purposes of administering this chapter. The
 451.32 legislature must not transfer money generated by these fees from the state government

452.1 special revenue fund to the general fund. ~~Surcharges collected by the commissioner of health~~
 452.2 ~~under section 16E.22 are not subject to this subdivision.~~

452.3 **EFFECTIVE DATE.** This section is effective January 1, 2018.

452.4 Sec. 30. Minnesota Statutes 2016, section 148.6448, is amended to read:

452.5 **148.6448 GROUNDS FOR DENIAL OF LICENSURE OR DISCIPLINE;**
 452.6 **INVESTIGATION PROCEDURES; DISCIPLINARY ACTIONS.**

452.7 Subdivision 1. **Grounds for denial of licensure or discipline.** The ~~commissioner~~ board
 452.8 may deny an application for licensure, may approve licensure with conditions, or may
 452.9 discipline a licensee using any disciplinary actions listed in subdivision 3 on proof that the
 452.10 individual has:

452.11 (1) intentionally submitted false or misleading information to the ~~commissioner~~ board
 452.12 or the advisory council;

452.13 (2) failed, within 30 days, to provide information in response to a written request by the
 452.14 ~~commissioner~~ board or advisory council;

452.15 (3) performed services of an occupational therapist or occupational therapy assistant in
 452.16 an incompetent manner or in a manner that falls below the community standard of care;

452.17 (4) failed to satisfactorily perform occupational therapy services during a period of
 452.18 temporary licensure;

452.19 (5) violated sections 148.6401 to ~~148.6450~~ 148.6449;

452.20 (6) failed to perform services with reasonable judgment, skill, or safety due to the use
 452.21 of alcohol or drugs, or other physical or mental impairment;

452.22 (7) been convicted of violating any state or federal law, rule, or regulation which directly
 452.23 relates to the practice of occupational therapy;

452.24 (8) aided or abetted another person in violating any provision of sections 148.6401 to
 452.25 ~~148.6450~~ 148.6449;

452.26 (9) been disciplined for conduct in the practice of an occupation by the state of Minnesota,
 452.27 another jurisdiction, or a national professional association, if any of the grounds for discipline
 452.28 are the same or substantially equivalent to those in sections 148.6401 to ~~148.6450~~ 148.6449;

452.29 (10) not cooperated with the ~~commissioner or advisory council~~ board in an investigation
 452.30 conducted according to subdivision 2;

452.31 (11) advertised in a manner that is false or misleading;

453.1 (12) engaged in dishonest, unethical, or unprofessional conduct in connection with the
453.2 practice of occupational therapy that is likely to deceive, defraud, or harm the public;

453.3 (13) demonstrated a willful or careless disregard for the health, welfare, or safety of a
453.4 client;

453.5 (14) performed medical diagnosis or provided treatment, other than occupational therapy,
453.6 without being licensed to do so under the laws of this state;

453.7 (15) paid or promised to pay a commission or part of a fee to any person who contacts
453.8 the occupational therapist for consultation or sends patients to the occupational therapist
453.9 for treatment;

453.10 (16) engaged in an incentive payment arrangement, other than that prohibited by clause
453.11 (15), that promotes occupational therapy overutilization, whereby the referring person or
453.12 person who controls the availability of occupational therapy services to a client profits
453.13 unreasonably as a result of client treatment;

453.14 (17) engaged in abusive or fraudulent billing practices, including violations of federal
453.15 Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical
453.16 assistance laws;

453.17 (18) obtained money, property, or services from a consumer through the use of undue
453.18 influence, high pressure sales tactics, harassment, duress, deception, or fraud;

453.19 (19) performed services for a client who had no possibility of benefiting from the services;

453.20 (20) failed to refer a client for medical evaluation when appropriate or when a client
453.21 indicated symptoms associated with diseases that could be medically or surgically treated;

453.22 (21) engaged in conduct with a client that is sexual or may reasonably be interpreted by
453.23 the client as sexual, or in any verbal behavior that is seductive or sexually demeaning to a
453.24 patient;

453.25 (22) violated a federal or state court order, including a conciliation court judgment, or
453.26 a disciplinary order issued by the ~~commissioner~~ board, related to the person's occupational
453.27 therapy practice; or

453.28 (23) any other just cause related to the practice of occupational therapy.

453.29 Subd. 2. **Investigation of complaints.** The ~~commissioner~~, or the ~~advisory council~~ when
453.30 ~~authorized by the commissioner~~, board may initiate an investigation upon receiving a
453.31 complaint or other oral or written communication that alleges or implies that a person has
453.32 violated sections 148.6401 to ~~148.6450~~ 148.6449. In the receipt, investigation, and hearing

454.1 of a complaint that alleges or implies a person has violated sections 148.6401 to ~~148.6450~~
454.2 148.6449, the ~~commissioner~~ board shall follow the procedures in section 214.10.

454.3 Subd. 3. **Disciplinary actions.** If the ~~commissioner~~ board finds that an occupational
454.4 therapist or occupational therapy assistant should be disciplined according to subdivision
454.5 1, the ~~commissioner~~ board may take any one or more of the following actions:

454.6 (1) refuse to grant or renew licensure;

454.7 (2) approve licensure with conditions;

454.8 (3) revoke licensure;

454.9 (4) suspend licensure;

454.10 (5) any reasonable lesser action including, but not limited to, reprimand or restriction
454.11 on licensure; or

454.12 (6) any action authorized by statute.

454.13 Subd. 4. **Effect of specific disciplinary action on use of title.** Upon notice from the
454.14 ~~commissioner~~ board denying licensure renewal or upon notice that disciplinary actions have
454.15 been imposed and the person is no longer entitled to practice occupational therapy and use
454.16 the occupational therapy and licensed titles, the person shall cease to practice occupational
454.17 therapy, to use titles protected by sections 148.6401 to ~~148.6450~~ 148.6449, and to represent
454.18 to the public that the person is licensed by the ~~commissioner~~ board.

454.19 Subd. 5. **Reinstatement requirements after disciplinary action.** A person who has
454.20 had licensure suspended may request and provide justification for reinstatement following
454.21 the period of suspension specified by the ~~commissioner~~ board. The requirements of sections
454.22 148.6423 and 148.6425 for renewing licensure and any other conditions imposed with the
454.23 suspension must be met before licensure may be reinstated.

454.24 Subd. 6. **Authority to contract.** The ~~commissioner~~ board shall contract with the health
454.25 professionals services program as authorized by sections 214.31 to 214.37 to provide these
454.26 services to practitioners under this chapter. The health professionals services program does
454.27 not affect the ~~commissioner's~~ board's authority to discipline violations of sections 148.6401
454.28 to ~~148.6450~~ 148.6449.

454.29 **EFFECTIVE DATE.** This section is effective January 1, 2018.

455.1 Sec. 31. [148.6449] BOARD OF OCCUPATIONAL THERAPY PRACTICE.

455.2 Subdivision 1. **Creation.** The Board of Occupational Therapy Practice consists of 11
455.3 members appointed by the governor. The members are:

455.4 (1) five occupational therapists licensed under sections 148.6401 to 148.6449;

455.5 (2) three occupational therapy assistants licensed under sections 148.6401 to 148.6449;

455.6 and

455.7 (3) three public members, including two members who have received occupational
455.8 therapy services or have a family member who has received occupational therapy services,
455.9 and one member who is a health care professional or health care provider licensed in
455.10 Minnesota.

455.11 Subd. 2. **Qualifications of board members.** (a) The occupational therapy practitioners
455.12 appointed to the board must represent a variety of practice areas and settings.

455.13 (b) At least two occupational therapy practitioners must be employed outside the
455.14 seven-county metropolitan area.

455.15 (c) Board members shall serve for not more than two consecutive terms.

455.16 Subd. 3. **Recommendations for appointment.** Prior to the end of the term of a member
455.17 of the board, or within 60 days after a position on the board becomes vacant, the Minnesota
455.18 Occupational Therapy Association and other interested persons and organizations may
455.19 recommend to the governor members qualified to serve on the board. The governor may
455.20 appoint members to the board from the list of persons recommended or from among other
455.21 qualified candidates.

455.22 Subd. 4. **Officers.** The board shall biennially elect from its membership a chair, vice-chair,
455.23 and secretary-treasurer. Each officer shall serve until a successor is elected.

455.24 Subd. 5. **Executive director.** The board shall appoint and employ an executive director
455.25 who is not a member of the board. The employment of the executive director shall be subject
455.26 to the terms described in section 214.04, subdivision 2a.

455.27 Subd. 6. **Terms; compensation; removal of members.** Membership terms, compensation
455.28 of members, removal of members, the filling of membership vacancies, and fiscal year and
455.29 reporting requirements shall be as provided in chapter 214. The provision of staff,
455.30 administrative services, and office space; the review and processing of complaints; the
455.31 setting of board fees; and other activities relating to board operations shall be conducted
455.32 according to chapter 214.

456.1 Subd. 7. Duties of the Board of Occupational Therapy Practice. (a) The board shall:

456.2 (1) adopt and enforce rules and laws necessary for licensing occupational therapy
456.3 practitioners;

456.4 (2) adopt and enforce rules for regulating the professional conduct of the practice of
456.5 occupational therapy;

456.6 (3) issue licenses to qualified individuals in accordance with sections 148.6401 to
456.7 148.6449;

456.8 (4) assess and collect fees for the issuance and renewal of licenses;

456.9 (5) educate the public about the requirements for licensing occupational therapy
456.10 practitioners, educate occupational therapy practitioners about the rules of conduct, and
456.11 enable the public to file complaints against applicants and licensees who may have violated
456.12 sections 148.6401 to 148.6449; and

456.13 (6) investigate individuals engaging in practices that violate sections 148.6401 to
456.14 148.6449 and take necessary disciplinary, corrective, or other action according to section
456.15 148.6448.

456.16 (b) The board may adopt rules necessary to define standards or carry out the provisions
456.17 of sections 148.6401 to 148.6449. Rules shall be adopted according to chapter 14.

456.18 **EFFECTIVE DATE.** This section is effective January 1, 2018.

456.19 Sec. 32. Minnesota Statutes 2016, section 148.881, is amended to read:

456.20 **148.881 DECLARATION OF POLICY.**

456.21 The practice of psychology in Minnesota affects the public health, safety, and welfare.
456.22 The regulations in ~~sections 148.88 to 148.98~~ the Minnesota Psychology Practice Act as
456.23 enforced by the Board of Psychology protect the public from the practice of psychology by
456.24 unqualified persons and from unethical or unprofessional conduct by persons licensed to
456.25 practice psychology through licensure and regulation to promote access to safe, ethical, and
456.26 competent psychological services.

456.27 Sec. 33. Minnesota Statutes 2016, section 148.89, is amended to read:

456.28 **148.89 DEFINITIONS.**

456.29 Subdivision 1. **Applicability.** For the purposes of sections 148.88 to 148.98, the following
456.30 terms have the meanings given them.

457.1 Subd. 2. **Board of Psychology or board.** "Board of Psychology" or "board" means the
457.2 board established under section 148.90.

457.3 Subd. 2a. **Client.** "Client" means ~~each individual or legal, religious, academic,~~
457.4 ~~organizational, business, governmental, or other entity that receives, received, or should~~
457.5 ~~have received, or arranged for another individual or entity to receive services from an~~
457.6 ~~individual regulated under sections 148.88 to 148.98. Client also means an individual's~~
457.7 ~~legally authorized representative, such as a parent or guardian. For the purposes of sections~~
457.8 ~~148.88 to 148.98, "client" may include patient, resident, counselee, evaluatee, and, as limited~~
457.9 ~~in the rules of conduct, student, supervisee, or research subject. In the case of dual clients,~~
457.10 ~~the licensee or applicant for licensure must be aware of the responsibilities to each client,~~
457.11 ~~and of the potential for divergent interests of each client~~ a direct recipient of psychological
457.12 services within the context of a professional relationship that may include a child, adolescent,
457.13 adult, couple, family, group, organization, community, or other entity. The client may be
457.14 the person requesting the psychological services or the direct recipient of the services.

457.15 Subd. 2b. **Credentialed.** "Credentialed" means having a license, certificate, charter,
457.16 registration, or similar authority to practice in an occupation regulated by a governmental
457.17 board or agency.

457.18 Subd. 2c. **Designated supervisor.** "Designated supervisor" means a qualified individual
457.19 who is ~~designated~~ identified and assigned by the primary supervisor to provide additional
457.20 supervision and training ~~to a licensed psychological practitioner or to an individual who is~~
457.21 ~~obtaining required predegree supervised professional experience or postdegree supervised~~
457.22 psychological employment.

457.23 Subd. 2d. **Direct services.** "Direct services" means the delivery of preventive, diagnostic,
457.24 assessment, or therapeutic intervention services where the primary purpose is to benefit a
457.25 client who is the direct recipient of the service.

457.26 Subd. 2e. **Full-time employment.** "Full-time employment" means a minimum of 35
457.27 clock hours per week.

457.28 Subd. 3. **Independent practice.** "Independent practice" means the practice of psychology
457.29 without supervision.

457.30 Subd. 3a. **Jurisdiction.** "Jurisdiction" means the United States, United States territories,
457.31 or Canadian provinces or territories.

457.32 Subd. 4. **Licensee.** "Licensee" means a person who is licensed by the board ~~as a licensed~~
457.33 ~~psychologist or as a licensed psychological practitioner.~~

458.1 Subd. 4a. **Provider or provider of services.** "Provider" or "provider of services" means
 458.2 any individual who is regulated by the board, ~~and includes a licensed psychologist, a licensed~~
 458.3 ~~psychological practitioner, a licensee, or an applicant.~~

458.4 Subd. 4b. **Primary supervisor.** "Primary supervisor" means a psychologist licensed in
 458.5 Minnesota or other qualified individual who provides the principal supervision ~~to a licensed~~
 458.6 ~~psychological practitioner~~ or to an individual who is obtaining required predegree supervised
 458.7 professional experience or postdegree supervised psychological employment.

458.8 Subd. 5. **Practice of psychology.** "Practice of psychology" means the observation,
 458.9 description, evaluation, interpretation, ~~or prediction, or~~ modification of human behavior by
 458.10 the application of psychological principles, methods, or procedures for any reason, including
 458.11 to prevent, eliminate, or manage the purpose of preventing, eliminating, evaluating, assessing,
 458.12 or predicting symptomatic, maladaptive, or undesired behavior; applying psychological
 458.13 principles in legal settings; and to enhance enhancing interpersonal relationships, work, life
 458.14 and developmental adjustment, personal and organizational effectiveness, behavioral health,
 458.15 and mental health. The practice of psychology includes, but is not limited to, the following
 458.16 services, regardless of whether the provider receives payment for the services:

458.17 (1) psychological research and teaching of psychology subject to the exemptions in
 458.18 section 148.9075;

458.19 (2) ~~assessment, including psychological testing and other means of evaluating personal~~
 458.20 ~~characteristics such as intelligence, personality, abilities, interests, aptitudes, and~~
 458.21 ~~neuropsychological functioning~~ psychological testing and the evaluation or assessment of
 458.22 personal characteristics, such as intelligence, personality, cognitive, physical and emotional
 458.23 abilities, skills, interests, aptitudes, and neuropsychological functioning;

458.24 (3) ~~a psychological report, whether written or oral, including testimony of a provider as~~
 458.25 ~~an expert witness, concerning the characteristics of an individual or entity~~ counseling,
 458.26 psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy;

458.27 (4) ~~psychotherapy, including but not limited to, categories such as behavioral, cognitive,~~
 458.28 ~~emotive, systems, psychophysiological, or insight-oriented therapies; counseling; hypnosis;~~
 458.29 ~~and diagnosis and treatment of:~~

458.30 (i) ~~mental and emotional disorder or disability;~~

458.31 (ii) ~~alcohol and substance dependence or abuse;~~

458.32 (iii) ~~disorders of habit or conduct;~~

459.1 ~~(iv) the psychological aspects of physical illness or condition, accident, injury, or~~
 459.2 ~~disability, including the psychological impact of medications;~~

459.3 ~~(v) life adjustment issues, including work-related and bereavement issues; and~~

459.4 ~~(vi) child, family, or relationship issues~~

459.5 (4) diagnosis, treatment, and management of mental or emotional disorders or disabilities,
 459.6 substance use disorders, disorders of habit or conduct, and the psychological aspects of
 459.7 physical illness, accident, injury, or disability;

459.8 ~~(5) psychoeducational services and treatment~~ psychoeducational evaluation, therapy,
 459.9 and remediation; and

459.10 ~~(6) consultation and supervision~~ with physicians, other health care professionals, and
 459.11 clients regarding available treatment options, including medication, with respect to the
 459.12 provision of care for a specific client;

459.13 (7) provision of direct services to individuals or groups for the purpose of enhancing
 459.14 individual and organizational effectiveness, using psychological principles, methods, and
 459.15 procedures to assess and evaluate individuals on personal characteristics for individual
 459.16 development or behavior change or for making decisions about the individual; and

459.17 (8) supervision and consultation related to any of the services described in this
 459.18 subdivision.

459.19 Subd. 6. **Telesupervision.** "Telesupervision" means the clinical supervision of
 459.20 psychological services through a synchronous audio and video format where the supervisor
 459.21 is not physically in the same facility as the supervisee.

459.22 Sec. 34. Minnesota Statutes 2016, section 148.90, subdivision 1, is amended to read:

459.23 Subdivision 1. **Board of Psychology.** (a) The Board of Psychology is created with the
 459.24 powers and duties described in this section. The board has 11 members who consist of:

459.25 (1) ~~three~~ four individuals licensed as licensed psychologists who have doctoral degrees
 459.26 in psychology;

459.27 (2) two individuals licensed as licensed psychologists who have master's degrees in
 459.28 psychology;

459.29 (3) two psychologists, not necessarily licensed, ~~one with a~~ who have doctoral degree
 459.30 degrees in psychology and one with either a doctoral or master's degree in psychology
 459.31 representing different training programs in psychology;

460.1 ~~(4) one individual licensed or qualified to be licensed as: (i) through December 31, 2010,~~
 460.2 ~~a licensed psychological practitioner; and (ii) after December 31, 2010, a licensed~~
 460.3 ~~psychologist; and~~

460.4 ~~(5)~~ (4) three public members.

460.5 (b) After the date on which fewer than 30 percent of the individuals licensed by the
 460.6 board as licensed psychologists qualify for licensure under section 148.907, subdivision 3,
 460.7 paragraph (b), vacancies filled under paragraph (a), clause (2), shall be filled by an individual
 460.8 with either a master's or doctoral degree in psychology licensed or qualified to be licensed
 460.9 as a licensed psychologist.

460.10 (c) After the date on which fewer than 15 percent of the individuals licensed by the board
 460.11 as licensed psychologists qualify for licensure under section 148.907, subdivision 3,
 460.12 paragraph (b), vacancies under paragraph (a), clause (2), shall be filled by an individual
 460.13 with either a master's or doctoral degree in psychology licensed or qualified to be licensed
 460.14 as a licensed psychologist.

460.15 Sec. 35. Minnesota Statutes 2016, section 148.90, subdivision 2, is amended to read:

460.16 Subd. 2. **Members.** (a) The members of the board shall:

460.17 (1) be appointed by the governor;

460.18 (2) be residents of the state;

460.19 (3) serve for not more than two consecutive terms;

460.20 (4) designate the officers of the board; and

460.21 (5) administer oaths pertaining to the business of the board.

460.22 (b) A public member of the board shall represent the public interest and shall not:

460.23 (1) be a psychologist, ~~psychological practitioner~~, or have engaged in the practice of
 460.24 psychology;

460.25 (2) be an applicant or former applicant for licensure;

460.26 (3) be a member of another health profession and be licensed by a health-related licensing
 460.27 board as defined under section 214.01, subdivision 2; the commissioner of health; or licensed,
 460.28 certified, or registered by another jurisdiction;

460.29 (4) be a member of a household that includes a psychologist ~~or psychological practitioner~~;
 460.30 or

- 461.1 (5) have conflicts of interest or the appearance of conflicts with duties as a board member.
- 461.2 Sec. 36. Minnesota Statutes 2016, section 148.905, subdivision 1, is amended to read:
- 461.3 Subdivision 1. **General.** The board shall:
- 461.4 (1) adopt and enforce rules for licensing psychologists ~~and psychological practitioners~~
- 461.5 and for regulating their professional conduct;
- 461.6 (2) adopt and enforce rules of conduct governing the practice of psychology;
- 461.7 (3) adopt and implement rules for examinations which shall be held at least once a year
- 461.8 to assess applicants' knowledge and skills. The examinations may be written or oral or both,
- 461.9 and may be administered by the board or by institutions or individuals designated by the
- 461.10 board; Before the adoption and implementation of a new national examination, the board
- 461.11 must consider whether the examination:
- 461.12 (i) demonstrates reasonable reliability and external validity;
- 461.13 (ii) is normed on a reasonable representative and diverse national sample; and
- 461.14 (iii) is intended to assess an applicant's education, training, and experience for the purpose
- 461.15 of public protection;
- 461.16 (4) issue licenses to individuals qualified under sections 148.907 ~~and 148.908~~, 148.909,
- 461.17 148.915, and 148.916, according to the procedures for licensing in Minnesota Rules;
- 461.18 (5) issue copies of the rules for licensing to all applicants;
- 461.19 (6) establish and maintain annually a register of current licenses;
- 461.20 (7) establish and collect fees for the issuance and renewal of licenses and other services
- 461.21 by the board. Fees shall be set to defray the cost of administering the provisions of sections
- 461.22 148.88 to 148.98 including costs for applications, examinations, enforcement, materials,
- 461.23 and the operations of the board;
- 461.24 (8) educate the public ~~about~~ on the requirements for ~~licensing of psychologists and of~~
- 461.25 ~~psychological practitioners~~ licenses issued by the board and about on the rules of conduct;
- 461.26 ~~to~~;
- 461.27 (9) enable the public to file complaints against applicants or licensees who may have
- 461.28 violated the Psychology Practice Act; ~~and~~
- 461.29 ~~(9)~~ (10) adopt and implement requirements for continuing education; and

462.1 (11) establish or approve programs that qualify for professional psychology continuing
462.2 educational credit. The board may hire consultants, agencies, or professional psychological
462.3 associations to establish and approve continuing education courses.

462.4 Sec. 37. Minnesota Statutes 2016, section 148.907, subdivision 1, is amended to read:

462.5 Subdivision 1. **Effective date.** ~~After August 1, 1991,~~ No person shall engage in the
462.6 independent practice of psychology unless that person is licensed as a licensed psychologist
462.7 or is exempt under section 148.9075.

462.8 Sec. 38. Minnesota Statutes 2016, section 148.907, subdivision 2, is amended to read:

462.9 Subd. 2. **Requirements for licensure as licensed psychologist.** To become licensed
462.10 by the board as a licensed psychologist, an applicant shall comply with the following
462.11 requirements:

462.12 (1) pass an examination in psychology;

462.13 (2) pass a professional responsibility examination on the practice of psychology;

462.14 (3) pass any other examinations as required by board rules;

462.15 (4) pay nonrefundable fees to the board for applications, processing, testing, renewals,
462.16 and materials;

462.17 (5) ~~have~~ attained the age of majority, be of good moral character, and have no unresolved
462.18 disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction;

462.19 (6) ~~have~~ earned a doctoral degree with a major in psychology from a regionally accredited
462.20 educational institution meeting the standards the board has established by rule; and

462.21 (7) ~~have~~ completed at least one full year or the equivalent in part time of postdoctoral
462.22 supervised psychological employment in no less than 12 months and no more than 60
462.23 months. If the postdoctoral supervised psychological employment goes beyond 60 months,
462.24 the board may grant a variance to this requirement.

462.25 Sec. 39. **[148.9075] EXEMPTIONS TO LICENSE REQUIREMENT.**

462.26 Subdivision 1. General. (a) Nothing in sections 148.88 to 148.98 shall prevent members
462.27 of other professions or occupations from performing functions for which they are competent
462.28 and properly authorized by law. The following individuals are exempt from the licensure
462.29 requirements of the Minnesota Psychology Practice Act, provided they operate in compliance
462.30 with the stated exemption:

463.1 (1) individuals licensed by a health-related licensing board as defined under section
463.2 214.01, subdivision 2, or by the commissioner of health;

463.3 (2) individuals authorized as mental health practitioners as defined under section 245.462,
463.4 subdivision 17; and

463.5 (3) individuals authorized as mental health professionals under section 245.462,
463.6 subdivision 18.

463.7 (b) Any of these individuals must not hold themselves out to the public by any title or
463.8 description stating or implying they are licensed to engage in the practice of psychology
463.9 unless they are licensed under sections 148.88 to 148.98 or are using a title in compliance
463.10 with section 148.96.

463.11 Subd. 2. **Business or industrial organization.** Nothing in sections 148.88 to 148.98
463.12 shall prevent the use of psychological techniques by a business or industrial organization
463.13 for its own personnel purposes or by an employment agency or state vocational rehabilitation
463.14 agency for the evaluation of the agency's clients prior to a recommendation for employment.
463.15 However, a representative of an industrial or business firm or corporation may not sell,
463.16 offer, or provide psychological services as specified in section 148.89, unless the services
463.17 are performed or supervised by an individual licensed under sections 148.88 to 148.98.

463.18 Subd. 3. **School psychologist.** (a) Nothing in sections 148.88 to 148.98 shall be construed
463.19 to prevent a person who holds a license or certificate issued by the State Board of Teaching
463.20 in accordance with chapters 122A and 129 from practicing school psychology within the
463.21 scope of employment if authorized by a board of education or by a private school that meets
463.22 the standards prescribed by the State Board of Teaching, or from practicing as a school
463.23 psychologist within the scope of employment in a program for children with disabilities.

463.24 (b) Any person exempted under this subdivision shall not offer psychological services
463.25 to any other individual, organization, or group for remuneration, monetary or otherwise,
463.26 unless the person is licensed by the Board of Psychology under sections 148.88 to 148.98.

463.27 Subd. 4. **Clergy or religious officials.** Nothing in sections 148.88 to 148.98 shall be
463.28 construed to prevent recognized religious officials, including ministers, priests, rabbis,
463.29 imams, Christian Science practitioners, and other persons recognized by the board, from
463.30 conducting counseling activities that are within the scope of the performance of their regular
463.31 recognizable religious denomination or sect, as defined in current federal tax regulations,
463.32 if the religious official does not refer to the official's self as a psychologist and the official
463.33 remains accountable to the established authority of the religious denomination or sect.

464.1 Subd. 5. **Teaching and research.** Nothing in sections 148.88 to 148.98 shall be construed
464.2 to prevent a person employed in a secondary, postsecondary, or graduate institution from
464.3 teaching and conducting research in psychology within an educational institution that is
464.4 recognized by a regional accrediting organization or by a federal, state, county, or local
464.5 government institution, agency, or research facility, so long as:

464.6 (1) the institution, agency, or facility provides appropriate oversight mechanisms to
464.7 ensure public protections; and

464.8 (2) the person is not providing direct clinical services to a client or clients as defined in
464.9 sections 148.88 to 148.98.

464.10 Subd. 6. **Psychologist in disaster or emergency relief.** Nothing in sections 148.88 to
464.11 148.98 shall be construed to prevent a psychologist sent to this state for the sole purpose of
464.12 responding to a disaster or emergency relief effort of the state government, the federal
464.13 government, the American Red Cross, or other disaster or emergency relief organization as
464.14 long as the psychologist is not practicing in Minnesota longer than 30 days and the sponsoring
464.15 organization can certify the psychologist's assignment to this state. The board or its designee,
464.16 at its discretion, may grant an extension to the 30-day time limitation of this subdivision.

464.17 Subd. 7. **Psychological consultant.** A license under sections 148.88 to 148.98 is not
464.18 required by a nonresident of the state, serving as an expert witness, organizational consultant,
464.19 presenter, or educator on a limited basis provided the person is appropriately trained,
464.20 educated, or has been issued a license, certificate, or registration by another jurisdiction.

464.21 Subd. 8. **Students.** Nothing in sections 148.88 to 148.98 shall prohibit the practice of
464.22 psychology under qualified supervision by a practicum psychology student, a predoctoral
464.23 psychology intern, or an individual who has earned a doctoral degree in psychology and is
464.24 in the process of completing their postdoctoral supervised psychological employment. A
464.25 student trainee or intern shall use the titles as required under section 148.96, subdivision 3.

464.26 Subd. 9. **Other professions.** Nothing in sections 148.88 to 148.98 shall be construed to
464.27 authorize a person licensed under sections 148.88 to 148.98 to engage in the practice of any
464.28 profession regulated under Minnesota law, unless the individual is duly licensed or registered
464.29 in that profession.

464.30 Sec. 40. **[148.9077] RELICENSURE.**

464.31 A former licensee may apply to the board for licensure after complying with all laws
464.32 and rules required for applicants for licensure that were in effect on the date the initial
464.33 Minnesota license was granted. The former licensee must verify to the board that the former

465.1 licensee has not engaged in the practice of psychology in this state since the last date of
 465.2 active licensure, except as permitted under statutory licensure exemption, and must submit
 465.3 a fee for relicensure.

465.4 Sec. 41. Minnesota Statutes 2016, section 148.9105, subdivision 1, is amended to read:

465.5 Subdivision 1. **Application.** Retired providers who are licensed or were formerly licensed
 465.6 to practice psychology in the state according to the Minnesota Psychology Practice Act may
 465.7 apply to the board for psychologist emeritus registration ~~or psychological practitioner~~
 465.8 ~~emeritus registration~~ if they declare that they are retired from the practice of psychology in
 465.9 Minnesota, have not been the subject of disciplinary action in any jurisdiction, and have no
 465.10 unresolved complaints in any jurisdiction. Retired providers shall complete the necessary
 465.11 forms provided by the board and pay a onetime, nonrefundable fee of \$150 at the time of
 465.12 application.

465.13 Sec. 42. Minnesota Statutes 2016, section 148.9105, subdivision 4, is amended to read:

465.14 Subd. 4. **Documentation of status.** A provider granted emeritus registration shall receive
 465.15 a document certifying that emeritus status has been granted by the board and that the
 465.16 registrant has completed the registrant's active career as a psychologist ~~or psychological~~
 465.17 ~~practitioner~~ licensed in good standing with the board.

465.18 Sec. 43. Minnesota Statutes 2016, section 148.9105, subdivision 5, is amended to read:

465.19 Subd. 5. **Representation to public.** In addition to the descriptions allowed in section
 465.20 148.96, subdivision 3, paragraph (e), former licensees who have been granted emeritus
 465.21 registration may represent themselves as "psychologist emeritus" ~~or "psychological~~
 465.22 ~~practitioner emeritus,"~~ but shall not represent themselves or allow themselves to be
 465.23 represented to the public as "licensed" or otherwise as current licensees of the board.

465.24 Sec. 44. Minnesota Statutes 2016, section 148.916, subdivision 1, is amended to read:

465.25 Subdivision 1. **Generally.** ~~If (a) A nonresident of the state of Minnesota, who is not~~
 465.26 ~~seeking licensure in this state, and who has been issued a license, certificate, or registration~~
 465.27 ~~by another jurisdiction to practice psychology at the doctoral level, wishes and who intends~~
 465.28 ~~to practice in Minnesota for more than seven calendar 30 days, the person shall apply to the~~
 465.29 ~~board for guest licensure, provided that.~~ The psychologist's practice in Minnesota is limited
 465.30 to no more than nine consecutive months per calendar year. Application under this section
 465.31 shall be made no less than 30 days prior to the expected date of practice in Minnesota and

466.1 shall be subject to approval by the board or its designee. ~~The board shall charge a~~
 466.2 ~~nonrefundable fee for guest licensure. The board shall adopt rules to implement this section.~~

466.3 (b) To be eligible for licensure under this section, the applicant must:

466.4 (1) have a license, certification, or registration to practice psychology from another
 466.5 jurisdiction;

466.6 (2) have a doctoral degree in psychology from a regionally accredited institution;

466.7 (3) be of good moral character;

466.8 (4) have no pending complaints or active disciplinary or corrective actions in any
 466.9 jurisdiction;

466.10 (5) pass a professional responsibility examination designated by the board; and

466.11 (6) pay a fee to the board.

466.12 Sec. 45. Minnesota Statutes 2016, section 148.916, subdivision 1a, is amended to read:

466.13 Subd. 1a. **Applicants for licensure.** (a) An applicant who is seeking licensure in this
 466.14 state, and who, at the time of application, is licensed, certified, or registered to practice
 466.15 psychology in another jurisdiction at the doctoral level may apply to the board for guest
 466.16 licensure in order to begin practicing psychology in this state while their application is being
 466.17 processed if the applicant is of good moral character and has no complaints, corrective, or
 466.18 disciplinary action pending in any jurisdiction.

466.19 (b) Application under this section subdivision shall be made no less than 30 days prior
 466.20 to the expected date of practice in this state, and must be made concurrently or after
 466.21 submission of an application for licensure as a licensed psychologist if applicable.

466.22 Applications under this section subdivision are subject to approval by the board or its
 466.23 designee. The board shall charge a fee for guest licensure under this subdivision.

466.24 ~~(b) The board shall charge a nonrefundable fee for guest licensure under this subdivision.~~

466.25 (c) A guest license issued under this subdivision shall be valid for one year from the
 466.26 date of issuance, or until the board has either issued a license or has denied the applicant's
 466.27 application for licensure, whichever is earlier. Guest licenses issued under this ~~section~~
 466.28 subdivision may be renewed annually until the board has denied the applicant's application
 466.29 for licensure.

467.1 Sec. 46. Minnesota Statutes 2016, section 148.925, is amended to read:

467.2 **148.925 SUPERVISION.**

467.3 Subdivision 1. **Supervision.** For the purpose of meeting the requirements of ~~this section~~
 467.4 the Minnesota Psychology Practice Act, supervision means documented in-person
 467.5 consultation, ~~which may include interactive, visual electronic communication, between~~
 467.6 ~~either: (1) a primary supervisor and a licensed psychological practitioner; or (2) a that~~
 467.7 employs a collaborative relationship that has both facilitative and evaluative components
 467.8 with the goal of enhancing the professional competence and science, and practice-informed
 467.9 professional work of the supervisee. Supervision may include telesupervision between
 467.10 ~~primary or designated supervisor~~ supervisors and an applicant for licensure as a licensed
 467.11 ~~psychologist~~ the supervisee. The supervision shall be adequate to assure the quality and
 467.12 competence of the activities supervised. Supervisory consultation shall include discussions
 467.13 on the nature and content of the practice of the supervisee, including, but not limited to, a
 467.14 review of a representative sample of psychological services in the supervisee's practice.

467.15 Subd. 2. **Postdegree supervised psychological employment.** Postdegree supervised
 467.16 psychological employment means required paid or volunteer work experience and postdegree
 467.17 training of an individual seeking to be licensed as a licensed psychologist that involves the
 467.18 professional oversight by a primary supervisor and satisfies the supervision requirements
 467.19 ~~in subdivisions 3 and 5~~ the Minnesota Psychology Practice Act.

467.20 Subd. 3. **Individuals qualified to provide supervision.** ~~(a) Supervision of a master's~~
 467.21 ~~level applicant for licensure as a licensed psychologist shall be provided by an individual:~~

467.22 ~~(1) who is a psychologist licensed in Minnesota with competence both in supervision~~
 467.23 ~~in the practice of psychology and in the activities being supervised;~~

467.24 ~~(2) who has a doctoral degree with a major in psychology, who is employed by a~~
 467.25 ~~regionally accredited educational institution or employed by a federal, state, county, or local~~
 467.26 ~~government institution, agency, or research facility, and who has competence both in~~
 467.27 ~~supervision in the practice of psychology and in the activities being supervised, provided~~
 467.28 ~~the supervision is being provided and the activities being supervised occur within that~~
 467.29 ~~regionally accredited educational institution or federal, state, county, or local government~~
 467.30 ~~institution, agency, or research facility;~~

467.31 ~~(3) who is licensed or certified as a psychologist in another jurisdiction and who has~~
 467.32 ~~competence both in supervision in the practice of psychology and in the activities being~~
 467.33 ~~supervised; or~~

468.1 ~~(4) who, in the case of a designated supervisor, is a master's or doctorally prepared~~
 468.2 ~~mental health professional.~~

468.3 ~~(b)~~ Supervision of a ~~doctoral level~~ an applicant for licensure as a licensed psychologist
 468.4 shall be provided by an individual:

468.5 (1) who is a psychologist licensed in Minnesota with a doctoral degree and competence
 468.6 both in supervision in the practice of psychology and in the activities being supervised;

468.7 (2) who has a doctoral degree with a major in psychology, who is employed by a
 468.8 regionally accredited educational institution or is employed by a federal, state, county, or
 468.9 local government institution, agency, or research facility, and who has competence both in
 468.10 supervision in the practice of psychology and in the activities being supervised, provided
 468.11 the supervision is being provided and the activities being supervised occur within that
 468.12 regionally accredited educational institution or federal, state, county, or local government
 468.13 institution, agency, or research facility;

468.14 (3) who is licensed or certified as a psychologist in another jurisdiction and who has
 468.15 competence both in supervision in the practice of psychology and in the activities being
 468.16 supervised;

468.17 (4) who is a psychologist licensed in Minnesota who was licensed before August 1,
 468.18 1991, with competence both in supervision in the practice of psychology and in the activities
 468.19 being supervised; or

468.20 (5) who, in the case of a designated supervisor, is a master's or doctorally prepared
 468.21 mental health professional.

468.22 ~~Subd. 4. **Supervisory consultation for a licensed psychological practitioner.**~~

468.23 ~~Supervisory consultation between a supervising licensed psychologist and a supervised~~
 468.24 ~~licensed psychological practitioner shall be at least one hour in duration and shall occur on~~
 468.25 ~~an individual, in-person basis. A minimum of one hour of supervision per month is required~~
 468.26 ~~for the initial 20 or fewer hours of psychological services delivered per month. For each~~
 468.27 ~~additional 20 hours of psychological services delivered per month, an additional hour of~~
 468.28 ~~supervision per month is required. When more than 20 hours of psychological services are~~
 468.29 ~~provided in a week, no more than one hour of supervision is required per week.~~

468.30 **Subd. 5. Supervisory consultation for an applicant for licensure as a licensed**
 468.31 **psychologist.** Supervision of an applicant for licensure as a licensed psychologist shall
 468.32 include at least two hours of regularly scheduled in-person consultations per week for
 468.33 full-time employment, one hour of which shall be with the supervisor on an individual basis.

469.1 The remaining hour may be with a designated supervisor. The board may approve an
469.2 exception to the weekly supervision requirement for a week when the supervisor was ill or
469.3 otherwise unable to provide supervision. The board may prorate the two hours per week of
469.4 supervision for individuals preparing for licensure on a part-time basis. Supervised
469.5 psychological employment does not qualify for licensure when the supervisory consultation
469.6 is not adequate as described in subdivision 1, or in the board rules.

469.7 Subd. 6. **Supervisee duties.** ~~Individuals~~ Applicants preparing for licensure as a licensed
469.8 psychologist during their postdegree supervised psychological employment may perform
469.9 as part of their training any functions of the services specified in section 148.89, subdivision
469.10 5, but only under qualified supervision.

469.11 ~~Subd. 7. **Variance from supervision requirements.** (a) An applicant for licensure as~~
469.12 ~~a licensed psychologist who entered supervised employment before August 1, 1991, may~~
469.13 ~~request a variance from the board from the supervision requirements in this section in order~~
469.14 ~~to continue supervision under the board rules in effect before August 1, 1991.~~

469.15 ~~(b) After a licensed psychological practitioner has completed two full years, or the~~
469.16 ~~equivalent, of supervised post-master's degree employment meeting the requirements of~~
469.17 ~~subdivision 5 as it relates to preparation for licensure as a licensed psychologist, the board~~
469.18 ~~shall grant a variance from the supervision requirements of subdivision 4 or 5 if the licensed~~
469.19 ~~psychological practitioner presents evidence of:~~

469.20 ~~(1) endorsement for specific areas of competency by the licensed psychologist who~~
469.21 ~~provided the two years of supervision;~~

469.22 ~~(2) employment by a hospital or by a community mental health center or nonprofit mental~~
469.23 ~~health clinic or social service agency providing services as a part of the mental health service~~
469.24 ~~plan required by the Comprehensive Mental Health Act;~~

469.25 ~~(3) the employer's acceptance of clinical responsibility for the care provided by the~~
469.26 ~~licensed psychological practitioner; and~~

469.27 ~~(4) a plan for supervision that includes at least one hour of regularly scheduled individual~~
469.28 ~~in-person consultations per week for full-time employment. The board may approve an~~
469.29 ~~exception to the weekly supervision requirement for a week when the supervisor was ill or~~
469.30 ~~otherwise unable to provide supervision.~~

469.31 ~~(e) Following the granting of a variance under paragraph (b), and completion of two~~
469.32 ~~additional full years or the equivalent of supervision and post-master's degree employment~~

470.1 ~~meeting the requirements of paragraph (b), the board shall grant a variance to a licensed~~
470.2 ~~psychological practitioner who presents evidence of:~~

470.3 ~~(1) endorsement for specific areas of competency by the licensed psychologist who~~
470.4 ~~provided the two years of supervision under paragraph (b);~~

470.5 ~~(2) employment by a hospital or by a community mental health center or nonprofit mental~~
470.6 ~~health clinic or social service agency providing services as a part of the mental health service~~
470.7 ~~plan required by the Comprehensive Mental Health Act;~~

470.8 ~~(3) the employer's acceptance of clinical responsibility for the care provided by the~~
470.9 ~~licensed psychological practitioner; and~~

470.10 ~~(4) a plan for supervision which includes at least one hour of regularly scheduled~~
470.11 ~~individual in-person supervision per month.~~

470.12 ~~(d) The variance allowed under this section must be deemed to have been granted to an~~
470.13 ~~individual who previously received a variance under paragraph (b) or (c) and is seeking a~~
470.14 ~~new variance because of a change of employment to a different employer or employment~~
470.15 ~~setting. The deemed variance continues until the board either grants or denies the variance.~~
470.16 ~~An individual who has been denied a variance under this section is entitled to seek~~
470.17 ~~reconsideration by the board.~~

470.18 Sec. 47. Minnesota Statutes 2016, section 148.96, subdivision 3, is amended to read:

470.19 Subd. 3. **Requirements for representations to public.** (a) Unless licensed under sections
470.20 148.88 to 148.98, except as provided in paragraphs (b) through (e), persons shall not represent
470.21 themselves or permit themselves to be represented to the public by:

470.22 (1) using any title or description of services incorporating the words "psychology,"
470.23 "psychological," "psychological practitioner," or "psychologist"; or

470.24 (2) representing that the person has expert qualifications in an area of psychology.

470.25 (b) Psychologically trained individuals who are employed by an educational institution
470.26 recognized by a regional accrediting organization, by a federal, state, county, or local
470.27 government institution, agency, or research facility, may represent themselves by the title
470.28 designated by that organization provided that the title does not indicate that the individual
470.29 is credentialed by the board.

470.30 (c) A psychologically trained individual from an institution described in paragraph (b)
470.31 may offer lecture services and is exempt from the provisions of this section.

471.1 (d) A person who is preparing for the practice of psychology under supervision in
471.2 accordance with board statutes and rules may be designated as a "psychological intern,"
471.3 "psychology fellow," "psychological trainee," or by other terms clearly describing the
471.4 person's training status.

471.5 (e) Former licensees who are completely retired from the practice of psychology may
471.6 represent themselves using the descriptions in paragraph (a), clauses (1) and (2), but shall
471.7 not represent themselves or allow themselves to be represented as current licensees of the
471.8 board.

471.9 ~~(f) Nothing in this section shall be construed to prohibit the practice of school psychology~~
471.10 ~~by a person licensed in accordance with chapters 122A and 129.~~

471.11 Sec. 48. Minnesota Statutes 2016, section 148B.53, subdivision 1, is amended to read:

471.12 Subdivision 1. **General requirements.** (a) To be licensed as a licensed professional
471.13 counselor (LPC), an applicant must provide evidence satisfactory to the board that the
471.14 applicant:

471.15 (1) is at least 18 years of age;

471.16 (2) is of good moral character;

471.17 (3) has completed a master's or doctoral degree program in counseling or a related field,
471.18 as determined by the board based on the criteria in paragraph (b), that includes a minimum
471.19 of 48 semester hours or 72 quarter hours and a supervised field experience of not fewer than
471.20 700 hours that is counseling in nature;

471.21 (4) has submitted to the board a plan for supervision during the first 2,000 hours of
471.22 professional practice or has submitted proof of supervised professional practice that is
471.23 acceptable to the board; and

471.24 (5) has demonstrated competence in professional counseling by passing the National
471.25 Counseling Exam (NCE) administered by the National Board for Certified Counselors, Inc.
471.26 (NBCC) or an equivalent national examination as determined by the board, and ethical,
471.27 oral, and situational examinations if prescribed by the board.

471.28 (b) The degree described in paragraph (a), clause (3), must be from a counseling program
471.29 recognized by the Council for Accreditation of Counseling and Related Education Programs
471.30 (CACREP) or from an institution of higher education that is accredited by a regional
471.31 accrediting organization recognized by the Council for Higher Education Accreditation

472.1 (CHEA). Specific academic course content and training must include course work in each
472.2 of the following subject areas:

472.3 (1) the helping relationship, including counseling theory and practice;

472.4 (2) human growth and development;

472.5 (3) lifestyle and career development;

472.6 (4) group dynamics, processes, counseling, and consulting;

472.7 (5) assessment and appraisal;

472.8 (6) social and cultural foundations, including multicultural issues;

472.9 (7) principles of etiology, treatment planning, and prevention of mental and emotional
472.10 disorders and dysfunctional behavior;

472.11 (8) family counseling and therapy;

472.12 (9) research and evaluation; and

472.13 (10) professional counseling orientation and ethics.

472.14 ~~(e) To be licensed as a professional counselor, a psychological practitioner licensed~~
472.15 ~~under section 148.908 need only show evidence of licensure under that section and is not~~
472.16 ~~required to comply with paragraph (a), clauses (1) to (3) and (5), or paragraph (b).~~

472.17 ~~(d)~~ (c) To be licensed as a professional counselor, a Minnesota licensed psychologist
472.18 need only show evidence of licensure from the Minnesota Board of Psychology and is not
472.19 required to comply with paragraph (a) or (b).

472.20 Sec. 49. Minnesota Statutes 2016, section 150A.06, subdivision 3, is amended to read:

472.21 Subd. 3. **Waiver of examination.** (a) All or any part of the examination for dentists ~~or~~
472.22 dental therapists, dental hygienists, or dental assistants, except that pertaining to the law of
472.23 Minnesota relating to dentistry and the rules of the board, may, at the discretion of the board,
472.24 be waived for an applicant who presents a certificate of having passed all components of
472.25 the National Board Dental Examinations or evidence of having maintained an adequate
472.26 scholastic standing as determined by the board, ~~in dental school as to dentists, or dental~~
472.27 ~~hygiene school as to dental hygienists.~~

472.28 (b) The board shall waive the clinical examination required for licensure for any dentist
472.29 applicant who is a graduate of a dental school accredited by the Commission on Dental
472.30 Accreditation, who has passed all components of the National Board Dental Examinations,
472.31 and who has satisfactorily completed a Minnesota-based postdoctoral general dentistry

473.1 residency program (GPR) or an advanced education in general dentistry (AEGD) program
473.2 after January 1, 2004. The postdoctoral program must be accredited by the Commission on
473.3 Dental Accreditation, be of at least one year's duration, and include an outcome assessment
473.4 evaluation assessing the resident's competence to practice dentistry. The board may require
473.5 the applicant to submit any information deemed necessary by the board to determine whether
473.6 the waiver is applicable.

473.7 Sec. 50. Minnesota Statutes 2016, section 150A.06, subdivision 8, is amended to read:

473.8 Subd. 8. **Licensure by credentials.** (a) Any dental assistant may, upon application and
473.9 payment of a fee established by the board, apply for licensure based on an evaluation of the
473.10 applicant's education, experience, and performance record in lieu of completing a
473.11 board-approved dental assisting program for expanded functions as defined in rule, and
473.12 may be interviewed by the board to determine if the applicant:

473.13 (1) has graduated from an accredited dental assisting program accredited by the
473.14 Commission on Dental Accreditation, ~~or~~ and is currently certified by the Dental Assisting
473.15 National Board;

473.16 (2) is not subject to any pending or final disciplinary action in another state or Canadian
473.17 province, or if not currently certified or registered, previously had a certification or
473.18 registration in another state or Canadian province in good standing that was not subject to
473.19 any final or pending disciplinary action at the time of surrender;

473.20 (3) is of good moral character and abides by professional ethical conduct requirements;

473.21 (4) at board discretion, has passed a board-approved English proficiency test if English
473.22 is not the applicant's primary language; and

473.23 (5) has met all expanded functions curriculum equivalency requirements of a Minnesota
473.24 board-approved dental assisting program.

473.25 (b) The board, at its discretion, may waive specific licensure requirements in paragraph
473.26 (a).

473.27 (c) An applicant who fulfills the conditions of this subdivision and demonstrates the
473.28 minimum knowledge in dental subjects required for licensure under subdivision 2a must
473.29 be licensed to practice the applicant's profession.

473.30 (d) If the applicant does not demonstrate the minimum knowledge in dental subjects
473.31 required for licensure under subdivision 2a, the application must be denied. If licensure is
473.32 denied, the board may notify the applicant of any specific remedy that the applicant could

474.1 take which, when passed, would qualify the applicant for licensure. A denial does not
474.2 prohibit the applicant from applying for licensure under subdivision 2a.

474.3 (e) A candidate whose application has been denied may appeal the decision to the board
474.4 according to subdivision 4a.

474.5 Sec. 51. Minnesota Statutes 2016, section 150A.10, subdivision 4, is amended to read:

474.6 Subd. 4. **Restorative procedures.** (a) Notwithstanding subdivisions 1, 1a, and 2, a
474.7 licensed dental hygienist or licensed dental assistant may perform the following restorative
474.8 procedures:

474.9 (1) place, contour, and adjust amalgam restorations;

474.10 (2) place, contour, and adjust glass ionomer;

474.11 (3) adapt and cement stainless steel crowns; and

474.12 ~~(4) place, contour, and adjust class I and class V supragingival composite restorations~~

474.13 ~~where the margins are entirely within the enamel; and~~

474.14 ~~(5)~~ (4) place, contour, and adjust class I, II₂ and class V supragingival composite

474.15 restorations on primary ~~teeth~~ and permanent dentition.

474.16 (b) The restorative procedures described in paragraph (a) may be performed only if:

474.17 (1) the licensed dental hygienist or licensed dental assistant has completed a

474.18 board-approved course on the specific procedures;

474.19 (2) the board-approved course includes a component that sufficiently prepares the licensed

474.20 dental hygienist or licensed dental assistant to adjust the occlusion on the newly placed

474.21 restoration;

474.22 (3) a licensed dentist or licensed advanced dental therapist has authorized the procedure

474.23 to be performed; and

474.24 (4) a licensed dentist or licensed advanced dental therapist is available in the clinic while

474.25 the procedure is being performed.

474.26 (c) The dental faculty who teaches the educators of the board-approved courses specified

474.27 in paragraph (b) must have prior experience teaching these procedures in an accredited

474.28 dental education program.

475.1 Sec. 52. Minnesota Statutes 2016, section 214.01, subdivision 2, is amended to read:

475.2 Subd. 2. **Health-related licensing board.** "Health-related licensing board" means the
475.3 Board of Examiners of Nursing Home Administrators established pursuant to section
475.4 144A.19, the Office of Unlicensed Complementary and Alternative Health Care Practice
475.5 established pursuant to section 146A.02, the Board of Medical Practice created pursuant to
475.6 section 147.01, the Board of Nursing created pursuant to section 148.181, the Board of
475.7 Chiropractic Examiners established pursuant to section 148.02, the Board of Optometry
475.8 established pursuant to section 148.52, the Board of Occupational Therapy Practice
475.9 established pursuant to section 148.6449, the Board of Physical Therapy established pursuant
475.10 to section 148.67, the Board of Psychology established pursuant to section 148.90, the Board
475.11 of Social Work pursuant to section 148E.025, the Board of Marriage and Family Therapy
475.12 pursuant to section 148B.30, the Board of Behavioral Health and Therapy established by
475.13 section 148B.51, the Board of Dietetics and Nutrition Practice established under section
475.14 148.622, the Board of Dentistry established pursuant to section 150A.02, the Board of
475.15 Pharmacy established pursuant to section 151.02, the Board of Podiatric Medicine established
475.16 pursuant to section 153.02, and the Board of Veterinary Medicine established pursuant to
475.17 section 156.01.

475.18 **EFFECTIVE DATE.** This section is effective January 1, 2018.

475.19 Sec. 53. **BOARD OF OCCUPATIONAL THERAPY PRACTICE.**

475.20 The governor shall appoint all members to the Board of Occupational Therapy Practice
475.21 under Minnesota Statutes, section 148.6449, by October 1, 2017. The governor shall designate
475.22 one member of the board to convene the first meeting of the board by November 1, 2017.
475.23 The board shall elect officers at its first meeting.

475.24 **EFFECTIVE DATE.** This section is effective July 1, 2017.

475.25 Sec. 54. **REVISOR'S INSTRUCTION.**

475.26 In Minnesota Statutes and Minnesota Rules, the revisor of statutes shall replace references
475.27 to Minnesota Statutes, section 148.6450, with Minnesota Statutes, section 148.6449.

475.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

475.29 Sec. 55. **REVISOR'S INSTRUCTION.**

475.30 The revisor of statutes shall change the headnote of Minnesota Statutes, section 147.0375,
475.31 to read "LICENSURE OF EMINENT PHYSICIANS."

476.1 **EFFECTIVE DATE.** This section is effective the day following final enactment.

476.2 Sec. 56. **REPEALER.**

476.3 (a) Minnesota Statutes 2016, sections 147A.21; 147B.08, subdivisions 1, 2, and 3;
 476.4 147C.40, subdivisions 1, 2, 3, and 4; 148.906; 148.907, subdivision 5; 148.908; 148.909,
 476.5 subdivision 7; and 148.96, subdivisions 4 and 5, are repealed.

476.6 (b) Minnesota Statutes 2016, sections 148.6402, subdivision 2; and 148.6450, are
 476.7 repealed.

476.8 (c) Minnesota Rules, part 5600.2500, is repealed.

476.9 (d) Minnesota Statutes 2016, section 147.0375, subdivision 7, is repealed.

476.10 **EFFECTIVE DATE.** Paragraphs (a) and (c) are effective July 1, 2017. Paragraph (b)
 476.11 is effective January 1, 2018. Paragraph (d) is effective the day following final enactment.

476.12 **ARTICLE 12**

476.13 **OPIATE ABUSE PREVENTION**

476.14 Section 1. Minnesota Statutes 2016, section 151.212, subdivision 2, is amended to read:

476.15 Subd. 2. **Controlled substances.** (a) In addition to the requirements of subdivision 1,
 476.16 when the use of any drug containing a controlled substance, as defined in chapter 152, or
 476.17 any other drug determined by the board, either alone or in conjunction with alcoholic
 476.18 beverages, may impair the ability of the user to operate a motor vehicle, the board shall
 476.19 require by rule that notice be prominently set forth on the label or container. Rules
 476.20 promulgated by the board shall specify exemptions from this requirement when there is
 476.21 evidence that the user will not operate a motor vehicle while using the drug.

476.22 (b) In addition to the requirements of subdivision 1, whenever a prescription drug
 476.23 containing an opiate is dispensed to a patient for outpatient use, the pharmacy or practitioner
 476.24 dispensing the drug must prominently display on the label or container a notice that states
 476.25 "Caution: Opioid. Risk of overdose and addiction."

476.26 Sec. 2. Minnesota Statutes 2016, section 152.11, is amended by adding a subdivision to
 476.27 read:

476.28 Subd. 4. **Limit on quantity of opiates prescribed for acute dental and ophthalmic**
 476.29 **pain.** (a) When used for the treatment of acute dental pain or acute pain associated with
 476.30 refractive surgery, prescriptions for opiate or narcotic pain relievers listed in Schedules II

477.1 through IV of section 152.02 shall not exceed a four-day supply. The quantity prescribed
477.2 shall be consistent with the dosage listed in the professional labeling for the drug that has
477.3 been approved by the United States Food and Drug Administration.

477.4 (b) For the purposes of this subdivision, "acute pain" means pain resulting from disease,
477.5 accidental or intentional trauma, surgery, or another cause, that the practitioner reasonably
477.6 expects to last only a short period of time. Acute pain does not include chronic pain or pain
477.7 being treated as part of cancer care, palliative care, or hospice or other end-of-life care.

477.8 (c) Notwithstanding paragraph (a), if in the professional clinical judgment of a practitioner
477.9 more than a four-day supply of a prescription listed in Schedules II through IV of section
477.10 152.02 is required to treat a patient's acute pain, the practitioner may issue a prescription
477.11 for the quantity needed to treat such acute pain.

477.12 Sec. 3. Minnesota Statutes 2016, section 256B.0625, subdivision 13e, is amended to read:

477.13 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall
477.14 be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by
477.15 the commissioner plus the fixed dispensing fee; or the usual and customary price charged
477.16 to the public. The amount of payment basis must be reduced to reflect all discount amounts
477.17 applied to the charge by any provider/insurer agreement or contract for submitted charges
477.18 to medical assistance programs. The net submitted charge may not be greater than the patient
477.19 liability for the service. The pharmacy dispensing fee shall be \$3.65 for legend prescription
477.20 drugs, except that the dispensing fee for intravenous solutions which must be compounded
477.21 by the pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and
477.22 \$30 per bag for total parenteral nutritional products dispensed in one liter quantities, or \$44
477.23 per bag for total parenteral nutritional products dispensed in quantities greater than one liter.
477.24 The pharmacy dispensing fee for over-the-counter drugs shall be \$3.65, except that the fee
477.25 shall be \$1.31 for retrospectively billing pharmacies when billing for quantities less than
477.26 the number of units contained in the manufacturer's original package. Actual acquisition
477.27 cost includes quantity and other special discounts except time and cash discounts. The actual
477.28 acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition
477.29 cost plus four percent for independently owned pharmacies located in a designated rural
477.30 area within Minnesota, and at wholesale acquisition cost plus two percent for all other
477.31 pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies
477.32 under the same ownership nationally. A "designated rural area" means an area defined as
477.33 a small rural area or isolated rural area according to the four-category classification of the
477.34 Rural Urban Commuting Area system developed for the United States Health Resources

478.1 and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug
478.2 acquired through the federal 340B Drug Pricing Program shall be estimated by the
478.3 commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost
478.4 is defined as the manufacturer's list price for a drug or biological to wholesalers or direct
478.5 purchasers in the United States, not including prompt pay or other discounts, rebates, or
478.6 reductions in price, for the most recent month for which information is available, as reported
478.7 in wholesale price guides or other publications of drug or biological pricing data. The
478.8 maximum allowable cost of a multisource drug may be set by the commissioner and it shall
478.9 be comparable to, but no higher than, the maximum amount paid by other third-party payors
478.10 in this state who have maximum allowable cost programs. Establishment of the amount of
478.11 payment for drugs shall not be subject to the requirements of the Administrative Procedure
478.12 Act.

478.13 (b) Pharmacies dispensing prescriptions to residents of long-term care facilities using
478.14 an automated drug distribution system meeting the requirements of section 151.58, or a
478.15 packaging system meeting the packaging standards set forth in Minnesota Rules, part
478.16 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ
478.17 retrospective billing for prescription drugs dispensed to long-term care facility residents. A
478.18 retrospectively billing pharmacy must submit a claim only for the quantity of medication
478.19 used by the enrolled recipient during the defined billing period. A retrospectively billing
478.20 pharmacy must use a billing period not less than one calendar month or 30 days.

478.21 (c) An additional dispensing fee of \$.30 may be added to the dispensing fee paid to
478.22 pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities
478.23 when a unit dose blister card system, approved by the department, is used. Under this type
478.24 of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National
478.25 Drug Code (NDC) from the drug container used to fill the blister card must be identified
478.26 on the claim to the department. The unit dose blister card containing the drug must meet
478.27 the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return
478.28 of unused drugs to the pharmacy for reuse. A pharmacy provider using packaging that meets
478.29 the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the
478.30 department for the actual acquisition cost of all unused drugs that are eligible for reuse,
478.31 unless the pharmacy is using retrospective billing. The commissioner may permit the drug
478.32 clozapine to be dispensed in a quantity that is less than a 30-day supply.

478.33 (d) Whenever a maximum allowable cost has been set for a multisource drug, payment
478.34 shall be the lower of the usual and customary price charged to the public or the maximum
478.35 allowable cost established by the commissioner unless prior authorization for the brand

479.1 name product has been granted according to the criteria established by the Drug Formulary
479.2 Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated
479.3 "dispense as written" on the prescription in a manner consistent with section 151.21,
479.4 subdivision 2.

479.5 (e) The basis for determining the amount of payment for drugs administered in an
479.6 outpatient setting shall be the lower of the usual and customary cost submitted by the
479.7 provider, 106 percent of the average sales price as determined by the United States
479.8 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
479.9 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
479.10 set by the commissioner. If average sales price is unavailable, the amount of payment must
479.11 be lower of the usual and customary cost submitted by the provider, the wholesale acquisition
479.12 cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner.
479.13 Effective January 1, 2014, the commissioner shall discount the payment rate for drugs
479.14 obtained through the federal 340B Drug Pricing Program by 20 percent. With the exception
479.15 of paragraph (f), the payment for drugs administered in an outpatient setting shall be made
479.16 to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug
479.17 for administration in an outpatient setting is not eligible for direct reimbursement.

479.18 (f) Payment for nonscheduled injectable drugs used to treat substance abuse administered
479.19 by a practitioner in an outpatient setting shall be made directly to the dispensing pharmacy.
479.20 The dispensing pharmacy shall submit the claim if the pharmacy dispenses the drug pursuant
479.21 to a prescription issued by the practitioner and delivers the filled prescription to the
479.22 practitioner for subsequent administration. Payment shall be made according to this section.
479.23 A pharmacy shall not dispense a practitioner-administered injectable drug described in this
479.24 paragraph directly to an enrollee. The commissioner may conduct postpayment review to
479.25 evaluate the effect of this paragraph on patient access, and shall report any findings to the
479.26 chairs and ranking minority members of the legislative committees with jurisdiction over
479.27 health and human service policy and finance by January 1, 2019.

479.28 (g) The commissioner may negotiate lower reimbursement rates for specialty pharmacy
479.29 products than the rates specified in paragraph (a). The commissioner may require individuals
479.30 enrolled in the health care programs administered by the department to obtain specialty
479.31 pharmacy products from providers with whom the commissioner has negotiated lower
479.32 reimbursement rates. Specialty pharmacy products are defined as those used by a small
479.33 number of recipients or recipients with complex and chronic diseases that require expensive
479.34 and challenging drug regimens. Examples of these conditions include, but are not limited
479.35 to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency,

480.1 Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical
480.2 products include injectable and infusion therapies, biotechnology drugs, antihemophilic
480.3 factor products, high-cost therapies, and therapies that require complex care. The
480.4 commissioner shall consult with the formulary committee to develop a list of specialty
480.5 pharmacy products subject to this paragraph. In consulting with the formulary committee
480.6 in developing this list, the commissioner shall take into consideration the population served
480.7 by specialty pharmacy products, the current delivery system and standard of care in the
480.8 state, and access to care issues. The commissioner shall have the discretion to adjust the
480.9 reimbursement rate to prevent access to care issues.

480.10 ~~(g)~~ (h) Home infusion therapy services provided by home infusion therapy pharmacies
480.11 must be paid at rates according to subdivision 8d.

480.12 **Sec. 4. REPORT ON OPIOID CRISIS GRANT; USE OF GRANT FUNDS.**

480.13 (a) The commissioner of human services, within two weeks of the annual project report
480.14 being submitted to the federal funder, shall report to the chairs and ranking minority members
480.15 of the legislative committees with jurisdiction over health and human services policy and
480.16 finance on:

480.17 (1) funds received under the 21st Century Cures Act, Public Law 114-255, section 1003,
480.18 Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted
480.19 Response to the Opioid Crisis Grants; and

480.20 (2) uses of the funds received, including a listing of grants provided and the amount
480.21 expended on personnel and administrative costs, travel, and public service announcements.

480.22 (b) The commissioner shall use remaining Opioid Crisis Grant funds, and any additional
480.23 funds received from other sources, to provide grants to counties for opioid abuse prevention
480.24 initiatives, increase public awareness of opioid abuse, and prevent opioid abuse through the
480.25 use of data analytics.

480.26 **Sec. 5. CHRONIC PAIN REHABILITATION THERAPY DEMONSTRATION**
480.27 **PROJECT.**

480.28 Subdivision 1. **Establishment.** The commissioner of human services shall award a
480.29 two-year grant to a rehabilitation institute located in Minneapolis operated by a nonprofit
480.30 foundation to participate in a bundled payment arrangement for chronic pain rehabilitation
480.31 therapy for adults who are eligible for fee-for-service medical assistance under Minnesota
480.32 Statutes, section 256B.055. The chronic pain rehabilitation therapy demonstration project

481.1 must include: nonnarcotic medication management, including opioid tapering;
481.2 interdisciplinary care coordination; and group and individual therapy in cognitive behavioral
481.3 therapy and physical therapy. The project may include self-management education in
481.4 nutrition, stress, mental health, substance use, or other modalities, if clinically appropriate.
481.5 The commissioner shall award the grant on a sole-source basis and the program design must
481.6 be mutually agreed upon by the commissioner and the grant recipient. Grant funds are
481.7 available until expended.

481.8 Subd. 2. **Performance measures.** The commissioner shall develop performance measures
481.9 to evaluate the demonstration project. These measures may include:

- 481.10 (1) reduction in medications, including opioids, taken for pain;
481.11 (2) reduction in emergency department and outpatient clinic utilization related to pain;
481.12 (3) improved ability to return to work, job search, or school;
481.13 (4) patient functional status and satisfaction; and
481.14 (5) rate of program completion.

481.15 Subd. 3. **Eligibility.** (a) To be eligible to participate in the demonstration project, an
481.16 individual must:

- 481.17 (1) be 21 years of age or older;
481.18 (2) be eligible for fee-for-service medical assistance under Minnesota Statutes, section
481.19 256B.055, and not have other health coverage; and
481.20 (3) meet criteria appropriate for chronic pain rehabilitation.

481.21 (b) In determining the criteria under paragraph (a), clause (3), the commissioner shall
481.22 consider, but is not required to include, the following:

- 481.23 (1) moderate to severe pain lasting longer than four months;
481.24 (2) an impairment in daily functioning, including work or activities of daily living;
481.25 (3) a referral from a physician or other qualified medical professional indicating that all
481.26 reasonable medical and surgical options have been exhausted; and
481.27 (4) willingness of the patient to engage in chronic pain rehabilitation therapies, including
481.28 opioid tapering.

481.29 Subd. 4. **Payment for services.** The bundled payment shall be billed on a per-person,
481.30 per-day payment and only for days the patient receives services from the grant recipient.
481.31 The grant recipient shall not receive a bundled payment for services provided to the patient

482.1 if a nonbundled medical assistance payment for a service that is part of the bundle is received
 482.2 for the same day of service.

482.3 Subd. 5. **Report.** The rehabilitation institute, for the duration of the demonstration
 482.4 project, must annually report on cost savings and performance indicators described in
 482.5 subdivision 2 to the commissioner of human services. One year after the completion of the
 482.6 demonstration project, the commissioner of human services shall submit a report to the
 482.7 chairs and ranking minority members of the legislative committees with jurisdiction over
 482.8 health care. The report shall include an evaluation of the demonstration project, based on
 482.9 the performance measures developed under subdivision 2, and may also include
 482.10 recommendations to increase individual access to chronic pain rehabilitation therapy through
 482.11 Minnesota health care programs.

482.12 **ARTICLE 13**

482.13 **MISCELLANEOUS**

482.14 Section 1. Minnesota Statutes 2016, section 62K.15, is amended to read:

482.15 **62K.15 ANNUAL OPEN ENROLLMENT PERIODS; SPECIAL ENROLLMENT**
 482.16 **PERIODS.**

482.17 (a) Health carriers offering individual health plans must limit annual enrollment in the
 482.18 individual market to the annual open enrollment periods for MNsure. Nothing in this section
 482.19 limits the application of special or limited open enrollment periods as defined under the
 482.20 Affordable Care Act.

482.21 (b) Health carriers offering individual health plans must inform all applicants at the time
 482.22 of application and enrollees at least annually of the open and special enrollment periods as
 482.23 defined under the Affordable Care Act.

482.24 (c) Health carriers offering individual health plans must provide a special enrollment
 482.25 period for enrollment in the individual market by employees of a small employer that offers
 482.26 a qualified small employer health reimbursement arrangement in accordance with United
 482.27 States Code, title 26, section 9831(d). The special enrollment period shall be available only
 482.28 to employees newly hired by a small employer offering a qualified small employer health
 482.29 reimbursement arrangement, and to employees employed by the small employer at the time
 482.30 the small employer initially offers a qualified small employer health reimbursement
 482.31 arrangement. For employees newly hired by the small employer, the special enrollment
 482.32 period shall last for 30 days after the employee's first day of employment. For employees
 482.33 employed by the small employer at the time the small employer initially offers a qualified

483.1 small employer health reimbursement arrangement, the special enrollment period shall last
483.2 for 30 days after the date the arrangement is initially offered to employees.

483.3 ~~(e)~~ (d) The commissioner of commerce shall enforce this section.

483.4 Sec. 2. Minnesota Statutes 2016, section 245A.02, subdivision 5a, is amended to read:

483.5 Subd. 5a. **Controlling individual.** (a) "Controlling individual" means a public body,
483.6 governmental agency, business entity, officer, owner, or managerial official whose
483.7 responsibilities include the direction of the management or policies of a program. For
483.8 purposes of this subdivision, owner means an individual who has direct or indirect ownership
483.9 interest in a corporation, partnership, or other business association issued a license under
483.10 this chapter. For purposes of this subdivision, managerial official means those individuals
483.11 who have the decision-making authority related to the operation of the program, and the
483.12 responsibility for the ongoing management of or direction of the policies, services, or
483.13 employees of the program. A site director who has no ownership interest in the program is
483.14 not considered to be a managerial official for purposes of this definition. Controlling
483.15 individual does not include an owner of a program or service provider licensed under this
483.16 chapter and the following individuals, if applicable:

483.17 (1) each officer of the organization, including the chief executive officer and chief
483.18 financial officer;

483.19 (2) the individual designated as the authorized agent under section 245A.04, subdivision
483.20 1, paragraph (b);

483.21 (3) the individual designated as the compliance officer under section 256B.04, subdivision
483.22 21, paragraph (b); and

483.23 (4) each managerial official whose responsibilities include the direction of the
483.24 management or policies of a program.

483.25 (b) Controlling individual does not include:

483.26 (1) a bank, savings bank, trust company, savings association, credit union, industrial
483.27 loan and thrift company, investment banking firm, or insurance company unless the entity
483.28 operates a program directly or through a subsidiary;

483.29 (2) an individual who is a state or federal official, or state or federal employee, or a
483.30 member or employee of the governing body of a political subdivision of the state or federal
483.31 government that operates one or more programs, unless the individual is also an officer,

484.1 owner, or managerial official of the program, receives remuneration from the program, or
 484.2 owns any of the beneficial interests not excluded in this subdivision;

484.3 (3) an individual who owns less than five percent of the outstanding common shares of
 484.4 a corporation:

484.5 (i) whose securities are exempt under section 80A.45, clause (6); or

484.6 (ii) whose transactions are exempt under section 80A.46, clause (2); ~~or~~

484.7 (4) an individual who is a member of an organization exempt from taxation under section
 484.8 290.05, unless the individual is also an officer, owner, or managerial official of the program
 484.9 or owns any of the beneficial interests not excluded in this subdivision. This clause does
 484.10 not exclude from the definition of controlling individual an organization that is exempt from
 484.11 taxation; or

484.12 (5) an employee stock ownership plan trust, or a participant or board member of an
 484.13 employee stock ownership plan, unless the participant or board member is a controlling
 484.14 individual according to paragraph (a).

484.15 (c) For purposes of this subdivision, "managerial official" means an individual who has
 484.16 the decision-making authority related to the operation of the program, and the responsibility
 484.17 for the ongoing management of or direction of the policies, services, or employees of the
 484.18 program. A site director who has no ownership interest in the program is not considered to
 484.19 be a managerial official for purposes of this definition.

484.20 Sec. 3. Minnesota Statutes 2016, section 245A.02, is amended by adding a subdivision to
 484.21 read:

484.22 Subd. 10b. **Owner.** "Owner" means an individual or organization that has a direct or
 484.23 indirect ownership interest of five percent or more in a program licensed under this chapter.
 484.24 For purposes of this subdivision, "direct ownership interest" means the possession of equity
 484.25 in capital, stock, or profits of an organization, and "indirect ownership interest" means a
 484.26 direct ownership interest in an entity that has a direct or indirect ownership interest in a
 484.27 licensed program. For purposes of this chapter, "owner of a nonprofit corporation" means
 484.28 the president and treasurer of the board of directors or, for an entity owned by an employee
 484.29 stock ownership plan, means the president and treasurer of the entity. A government entity
 484.30 that is issued a license under this chapter shall be designated the owner.

485.1 Sec. 4. [256.999] LEGISLATIVE NOTICE AND APPROVAL REQUIRED FOR
485.2 CERTAIN FEDERAL WAIVERS OR APPROVALS.

485.3 (a) Before submitting an application for a federal waiver or approval (1) under section
485.4 1332 of the Affordable Care Act or section 1115 of the Social Security Act, or (2) to modify
485.5 or add a benefit covered by medical assistance or otherwise amend the state's Medicaid
485.6 plan, the commissioner, governing board, or director of a state agency seeking the federal
485.7 waiver or approval must provide notice and a copy of the application for the federal waiver
485.8 or approval to the chairs and ranking minority members of the legislative committees with
485.9 jurisdiction over health and human services policy and finance and commerce.

485.10 (b) If a federal waiver or approval (1) under section 1332 of the Affordable Care Act or
485.11 section 1115 of the Social Security Act, or (2) to modify or add a benefit covered by medical
485.12 assistance or otherwise amend the state's Medicaid plan, is received or granted during a
485.13 legislative session, a commissioner, governing board, or director of a state agency is
485.14 prohibited from implementing or otherwise acting on the federal waiver or approval received
485.15 or granted, unless the federal waiver or approval is specifically authorized by law on a date
485.16 after receipt of the federal waiver or approval.

485.17 (c) If a federal waiver or approval (1) under section 1332 of the Affordable Care Act or
485.18 section 1115 of the Social Security Act, or (2) to modify or add a benefit covered by medical
485.19 assistance or otherwise amend the state's Medicaid plan, is received or granted while the
485.20 legislature is not in session, a commissioner, governing board, or director of a state agency
485.21 is prohibited from implementing or otherwise acting on the federal waiver or approval
485.22 received or granted, unless the federal waiver or approval is submitted to the Legislative
485.23 Advisory Commission and the commission makes a positive recommendation. If the
485.24 commission makes no recommendation, a negative recommendation, or a recommendation
485.25 for further review, the commissioner, governing board, or director shall not implement or
485.26 otherwise act on the federal waiver or approval received or granted.

485.27 **EFFECTIVE DATE.** This section is effective the day following final enactment and
485.28 applies to initial requests for federal waivers or approvals sought on or after that date.

485.29 Sec. 5. ESTABLISHMENT OF FEDERALLY FACILITATED MARKETPLACE.

485.30 Subdivision 1. **Establishment.** (a) The commissioner of commerce, in cooperation with
485.31 the secretary of the United States Department of Health and Human Services, shall establish
485.32 a federally facilitated marketplace for Minnesota for coverage beginning January 1, 2019.
485.33 The federally facilitated marketplace shall take the place of MNsure, established under
485.34 Minnesota Statutes, chapter 62V. In working with the secretary of the United States

486.1 Department of Health and Human Services to implement the federally facilitated marketplace
486.2 in Minnesota, the commissioner of commerce shall:

486.3 (1) seek to incorporate, where appropriate and cost-effective, elements of the Minnesota
486.4 eligibility system as defined in Minnesota Statutes, section 62V.055, subdivision 1;

486.5 (2) regularly consult with stakeholder groups, including but not limited to representatives
486.6 of state agencies, health care providers, health plan companies, brokers, and consumers;
486.7 and

486.8 (3) seek all available federal grants and funds for state planning and development costs.

486.9 (b) All health plans that are offered to Minnesota residents through the federally facilitated
486.10 marketplace, when implemented, and that are offered by a health carrier that meets the
486.11 applicability criteria in Minnesota Statutes, section 62K.10, subdivision 1, must satisfy
486.12 requirements for:

486.13 (1) geographic accessibility to providers that at least satisfy the maximum distance or
486.14 travel times specified in Minnesota Statutes, section 62K.10, subdivisions 2 and 3; and

486.15 (2) provider network adequacy that guarantees at least the level of network adequacy
486.16 required by Minnesota Statutes, section 62K.10, subdivision 4.

486.17 For purposes of this paragraph, "health plan" has the meaning given in Minnesota Statutes,
486.18 section 62A.011, subdivision 3, and "health carrier" has the meaning given in Minnesota
486.19 Statutes, section 62A.011, subdivision 2.

486.20 Subd. 2. **Implementation plan; draft legislation.** The commissioner of commerce, in
486.21 consultation with the commissioner of human services, the chief information officer of
486.22 MN.IT, and the MNSure board, shall develop and present to the 2018 legislature an
486.23 implementation plan for conversion to a federally facilitated marketplace. The plan must:

486.24 (1) address and provide recommendations on the following issues:

486.25 (i) the state agency or other entity responsible for state oversight and administration
486.26 related to the state's use of the federally facilitated marketplace;

486.27 (ii) plan management functions, including certification of qualified health plans;

486.28 (iii) the operation of navigator and in-person assister programs, and the operation of a
486.29 call center and Web site;

486.30 (iv) funding for federally facilitated marketplace activities, including a user fee rate that
486.31 shall not exceed the federal platform user fee rate of two percent of premiums charged for
486.32 a coverage year; and

487.1 (v) administration of MinnesotaCare as a basic health plan by the commissioner of
487.2 human services;

487.3 (2) address and provide recommendations on the funding and operation of the system
487.4 to be used for public health care program eligibility determinations. These recommendations
487.5 must be developed in consultation with the Minnesota eligibility system executive steering
487.6 committee established under Minnesota Statutes, section 62V.055; and

487.7 (3) include draft legislation for any changes in state law necessary to implement a
487.8 federally facilitated marketplace, including but not limited to necessary changes to Laws
487.9 2013, chapter 84, and technical and conforming changes related to the repeal of Minnesota
487.10 Statutes, chapter 62V.

487.11 Subd. 3. **Vendor contract.** The commissioner of commerce, in consultation with the
487.12 commissioner of human services, the chief information officer of MN.IT, and the MNsure
487.13 board, shall contract with a vendor to provide technical assistance in developing and
487.14 implementing the plan for conversion to a federally facilitated marketplace.

487.15 Sec. 6. **REPEALER.**

487.16 Minnesota Statutes 2016, sections 62V.01; 62V.02; 62V.03; 62V.04; 62V.05; 62V.051;
487.17 62V.055; 62V.06; 62V.07; 62V.08; 62V.09; 62V.10; and 62V.11, are repealed effective
487.18 January 1, 2019.

487.19 **ARTICLE 14**

487.20 **NURSING FACILITY TECHNICAL CORRECTIONS**

487.21 Section 1. Minnesota Statutes 2016, section 144.0722, subdivision 1, is amended to read:

487.22 Subdivision 1. **Resident reimbursement classifications.** The commissioner of health
487.23 shall establish resident reimbursement classifications based upon the assessments of residents
487.24 of nursing homes and boarding care homes conducted under section 144.0721, or under
487.25 rules established by the commissioner of human services under ~~sections 256B.41 to 256B.48~~
487.26 chapter 256R. The reimbursement classifications established by the commissioner must
487.27 conform to the rules established by the commissioner of human services.

487.28 Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 1, is amended to read:

487.29 Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner
487.30 of health shall establish resident reimbursement classifications based upon the assessments

488.1 of residents of nursing homes and boarding care homes conducted under this section and
488.2 according to section ~~256B.438~~ 256R.17.

488.3 Sec. 3. Minnesota Statutes 2016, section 144.0724, subdivision 2, is amended to read:

488.4 Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings
488.5 given.

488.6 (a) "Assessment reference date" or "ARD" means the specific end point for look-back
488.7 periods in the MDS assessment process. This look-back period is also called the observation
488.8 or assessment period.

488.9 (b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

488.10 (c) "Index maximization" means classifying a resident who could be assigned to more
488.11 than one category, to the category with the highest case mix index.

488.12 (d) "Minimum data set" or "MDS" means a core set of screening, clinical assessment,
488.13 and functional status elements, that include common definitions and coding categories
488.14 specified by the Centers for Medicare and Medicaid Services and designated by the
488.15 Minnesota Department of Health.

488.16 (e) "Representative" means a person who is the resident's guardian or conservator, the
488.17 person authorized to pay the nursing home expenses of the resident, a representative of the
488.18 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any
488.19 other individual designated by the resident.

488.20 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
488.21 facility's residents according to their clinical and functional status identified in data supplied
488.22 by the facility's minimum data set.

488.23 (g) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility,
488.24 positioning, eating, and toileting.

488.25 (h) "Nursing facility level of care determination" means the assessment process that
488.26 results in a determination of a resident's or prospective resident's need for nursing facility
488.27 level of care as established in subdivision 11 for purposes of medical assistance payment
488.28 of long-term care services for:

488.29 (1) nursing facility services under section 256B.434 or ~~256B.441~~ chapter 256R;

488.30 (2) elderly waiver services under section 256B.0915;

488.31 (3) CADI and BI waiver services under section 256B.49; and

489.1 (4) state payment of alternative care services under section 256B.0913.

489.2 Sec. 4. Minnesota Statutes 2016, section 144.0724, subdivision 9, is amended to read:

489.3 Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident
489.4 assessments performed under section ~~256B.438~~ 256R.17 through any of the following: desk
489.5 audits; on-site review of residents and their records; and interviews with staff, residents, or
489.6 residents' families. The commissioner shall reclassify a resident if the commissioner
489.7 determines that the resident was incorrectly classified.

489.8 (b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

489.9 (c) A facility must grant the commissioner access to examine the medical records relating
489.10 to the resident assessments selected for audit under this subdivision. The commissioner may
489.11 also observe and speak to facility staff and residents.

489.12 (d) The commissioner shall consider documentation under the time frames for coding
489.13 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment
489.14 Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

489.15 (e) The commissioner shall develop an audit selection procedure that includes the
489.16 following factors:

489.17 (1) Each facility shall be audited annually. If a facility has two successive audits in which
489.18 the percentage of change is five percent or less and the facility has not been the subject of
489.19 a special audit in the past 36 months, the facility may be audited biannually. A stratified
489.20 sample of 15 percent, with a minimum of ten assessments, of the most current assessments
489.21 shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed
489.22 as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a
489.23 minimum of ten assessments. If the total change between the first and second samples is
489.24 35 percent or greater, the commissioner may expand the audit to all of the remaining
489.25 assessments.

489.26 (2) If a facility qualifies for an expanded audit, the commissioner may audit the facility
489.27 again within six months. If a facility has two expanded audits within a 24-month period,
489.28 that facility will be audited at least every six months for the next 18 months.

489.29 (3) The commissioner may conduct special audits if the commissioner determines that
489.30 circumstances exist that could alter or affect the validity of case mix classifications of
489.31 residents. These circumstances include, but are not limited to, the following:

489.32 (i) frequent changes in the administration or management of the facility;

- 490.1 (ii) an unusually high percentage of residents in a specific case mix classification;
- 490.2 (iii) a high frequency in the number of reconsideration requests received from a facility;
- 490.3 (iv) frequent adjustments of case mix classifications as the result of reconsiderations or
- 490.4 audits;
- 490.5 (v) a criminal indictment alleging provider fraud;
- 490.6 (vi) other similar factors that relate to a facility's ability to conduct accurate assessments;
- 490.7 (vii) an atypical pattern of scoring minimum data set items;
- 490.8 (viii) nonsubmission of assessments;
- 490.9 (ix) late submission of assessments; or
- 490.10 (x) a previous history of audit changes of 35 percent or greater.

490.11 (f) Within 15 working days of completing the audit process, the commissioner shall

490.12 make available electronically the results of the audit to the facility. If the results of the audit

490.13 reflect a change in the resident's case mix classification, a case mix classification notice

490.14 will be made available electronically to the facility, using the procedure in subdivision 7,

490.15 paragraph (a). The notice must contain the resident's classification and a statement informing

490.16 the resident, the resident's authorized representative, and the facility of their right to review

490.17 the commissioner's documents supporting the classification and to request a reconsideration

490.18 of the classification. This notice must also include the address and telephone number of the

490.19 Office of Ombudsman for Long-Term Care.

490.20 Sec. 5. Minnesota Statutes 2016, section 144A.071, subdivision 3, is amended to read:

490.21 Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The

490.22 commissioner of health, in coordination with the commissioner of human services, may

490.23 approve the addition of new licensed and Medicare and Medicaid certified nursing home

490.24 beds, using the criteria and process set forth in this subdivision.

490.25 (b) The commissioner, in cooperation with the commissioner of human services, shall

490.26 consider the following criteria when determining that an area of the state is a hardship area

490.27 with regard to access to nursing facility services:

490.28 (1) a low number of beds per thousand in a specified area using as a standard the beds

490.29 per thousand people age 65 and older, in five year age groups, using data from the most

490.30 recent census and population projections, weighted by each group's most recent nursing

491.1 home utilization, of the county at the 20th percentile, as determined by the commissioner
491.2 of human services;

491.3 (2) a high level of out-migration for nursing facility services associated with a described
491.4 area from the county or counties of residence to other Minnesota counties, as determined
491.5 by the commissioner of human services, using as a standard an amount greater than the
491.6 out-migration of the county ranked at the 50th percentile;

491.7 (3) an adequate level of availability of noninstitutional long-term care services measured
491.8 as public spending for home and community-based long-term care services per individual
491.9 age 65 and older, in five year age groups, using data from the most recent census and
491.10 population projections, weighted by each group's most recent nursing home utilization, as
491.11 determined by the commissioner of human services using as a standard an amount greater
491.12 than the 50th percentile of counties;

491.13 (4) there must be a declaration of hardship resulting from insufficient access to nursing
491.14 home beds by local county agencies and area agencies on aging; and

491.15 (5) other factors that may demonstrate the need to add new nursing facility beds.

491.16 (c) On August 15 of odd-numbered years, the commissioner, in cooperation with the
491.17 commissioner of human services, may publish in the State Register a request for information
491.18 in which interested parties, using the data provided under section 144A.351, along with any
491.19 other relevant data, demonstrate that a specified area is a hardship area with regard to access
491.20 to nursing facility services. For a response to be considered, the commissioner must receive
491.21 it by November 15. The commissioner shall make responses to the request for information
491.22 available to the public and shall allow 30 days for comment. The commissioner shall review
491.23 responses and comments and determine if any areas of the state are to be declared hardship
491.24 areas.

491.25 (d) For each designated hardship area determined in paragraph (c), the commissioner
491.26 shall publish a request for proposals in accordance with section 144A.073 and Minnesota
491.27 Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the
491.28 State Register by March 15 following receipt of responses to the request for information.
491.29 The request for proposals must specify the number of new beds which may be added in the
491.30 designated hardship area, which must not exceed the number which, if added to the existing
491.31 number of beds in the area, including beds in layaway status, would have prevented it from
491.32 being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1,
491.33 2011, the number of new beds approved must not exceed 200 beds statewide per biennium.
491.34 After June 30, 2019, the number of new beds that may be approved in a biennium must not

492.1 exceed 300 statewide. For a proposal to be considered, the commissioner must receive it
 492.2 within six months of the publication of the request for proposals. The commissioner shall
 492.3 review responses to the request for proposals and shall approve or disapprove each proposal
 492.4 by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts
 492.5 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a
 492.6 comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of
 492.7 a proposal expires after 18 months unless the facility has added the new beds using existing
 492.8 space, subject to approval by the commissioner, or has commenced construction as defined
 492.9 in section 144A.071, subdivision 1a, paragraph (d). If, after the approved beds have been
 492.10 added, fewer than 50 percent of the beds in a facility are newly licensed, the operating
 492.11 payment rates previously in effect shall remain. If, after the approved beds have been added,
 492.12 50 percent or more of the beds in a facility are newly licensed, operating payment rates shall
 492.13 be determined according to Minnesota Rules, part 9549.0057, using the limits under ~~section~~
 492.14 ~~256B.441~~ sections 256R.23, subdivision 5, and 256R.24, subdivision 3. External fixed costs
 492.15 payment rates must be determined according to section ~~256B.441, subdivision 53~~ 256R.25.
 492.16 Property payment rates for facilities with beds added under this subdivision must be
 492.17 determined in the same manner as rate determinations resulting from projects approved and
 492.18 completed under section 144A.073.

492.19 (e) The commissioner may:

492.20 (1) certify or license new beds in a new facility that is to be operated by the commissioner
 492.21 of veterans affairs or when the costs of constructing and operating the new beds are to be
 492.22 reimbursed by the commissioner of veterans affairs or the United States Veterans
 492.23 Administration; and

492.24 (2) license or certify beds in a facility that has been involuntarily delicensed or decertified
 492.25 for participation in the medical assistance program, provided that an application for
 492.26 relicensure or recertification is submitted to the commissioner by an organization that is
 492.27 not a related organization as defined in section ~~256B.441, subdivision 34~~ 256R.02,
 492.28 subdivision 43, to the prior licensee within 120 days after delicensure or decertification.

492.29 Sec. 6. Minnesota Statutes 2016, section 144A.071, subdivision 4a, is amended to read:

492.30 Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to
 492.31 ensure that nursing homes and boarding care homes continue to meet the physical plant
 492.32 licensing and certification requirements by permitting certain construction projects. Facilities
 492.33 should be maintained in condition to satisfy the physical and emotional needs of residents
 492.34 while allowing the state to maintain control over nursing home expenditure growth.

493.1 The commissioner of health in coordination with the commissioner of human services,
493.2 may approve the renovation, replacement, upgrading, or relocation of a nursing home or
493.3 boarding care home, under the following conditions:

493.4 (a) to license or certify beds in a new facility constructed to replace a facility or to make
493.5 repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire,
493.6 lightning, or other hazard provided:

493.7 (i) destruction was not caused by the intentional act of or at the direction of a controlling
493.8 person of the facility;

493.9 (ii) at the time the facility was destroyed or damaged the controlling persons of the
493.10 facility maintained insurance coverage for the type of hazard that occurred in an amount
493.11 that a reasonable person would conclude was adequate;

493.12 (iii) the net proceeds from an insurance settlement for the damages caused by the hazard
493.13 are applied to the cost of the new facility or repairs;

493.14 (iv) the number of licensed and certified beds in the new facility does not exceed the
493.15 number of licensed and certified beds in the destroyed facility; and

493.16 (v) the commissioner determines that the replacement beds are needed to prevent an
493.17 inadequate supply of beds.

493.18 Project construction costs incurred for repairs authorized under this clause shall not be
493.19 considered in the dollar threshold amount defined in subdivision 2;

493.20 (b) to license or certify beds that are moved from one location to another within a nursing
493.21 home facility, provided the total costs of remodeling performed in conjunction with the
493.22 relocation of beds does not exceed \$1,000,000;

493.23 (c) to license or certify beds in a project recommended for approval under section
493.24 144A.073;

493.25 (d) to license or certify beds that are moved from an existing state nursing home to a
493.26 different state facility, provided there is no net increase in the number of state nursing home
493.27 beds;

493.28 (e) to certify and license as nursing home beds boarding care beds in a certified boarding
493.29 care facility if the beds meet the standards for nursing home licensure, or in a facility that
493.30 was granted an exception to the moratorium under section 144A.073, and if the cost of any
493.31 remodeling of the facility does not exceed \$1,000,000. If boarding care beds are licensed
493.32 as nursing home beds, the number of boarding care beds in the facility must not increase

494.1 beyond the number remaining at the time of the upgrade in licensure. The provisions
494.2 contained in section 144A.073 regarding the upgrading of the facilities do not apply to
494.3 facilities that satisfy these requirements;

494.4 (f) to license and certify up to 40 beds transferred from an existing facility owned and
494.5 operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the
494.6 same location as the existing facility that will serve persons with Alzheimer's disease and
494.7 other related disorders. The transfer of beds may occur gradually or in stages, provided the
494.8 total number of beds transferred does not exceed 40. At the time of licensure and certification
494.9 of a bed or beds in the new unit, the commissioner of health shall delicense and decertify
494.10 the same number of beds in the existing facility. As a condition of receiving a license or
494.11 certification under this clause, the facility must make a written commitment to the
494.12 commissioner of human services that it will not seek to receive an increase in its
494.13 property-related payment rate as a result of the transfers allowed under this paragraph;

494.14 (g) to license and certify nursing home beds to replace currently licensed and certified
494.15 boarding care beds which may be located either in a remodeled or renovated boarding care
494.16 or nursing home facility or in a remodeled, renovated, newly constructed, or replacement
494.17 nursing home facility within the identifiable complex of health care facilities in which the
494.18 currently licensed boarding care beds are presently located, provided that the number of
494.19 boarding care beds in the facility or complex are decreased by the number to be licensed as
494.20 nursing home beds and further provided that, if the total costs of new construction,
494.21 replacement, remodeling, or renovation exceed ten percent of the appraised value of the
494.22 facility or \$200,000, whichever is less, the facility makes a written commitment to the
494.23 commissioner of human services that it will not seek to receive an increase in its
494.24 property-related payment rate by reason of the new construction, replacement, remodeling,
494.25 or renovation. The provisions contained in section 144A.073 regarding the upgrading of
494.26 facilities do not apply to facilities that satisfy these requirements;

494.27 (h) to license as a nursing home and certify as a nursing facility a facility that is licensed
494.28 as a boarding care facility but not certified under the medical assistance program, but only
494.29 if the commissioner of human services certifies to the commissioner of health that licensing
494.30 the facility as a nursing home and certifying the facility as a nursing facility will result in
494.31 a net annual savings to the state general fund of \$200,000 or more;

494.32 (i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home
494.33 beds in a facility that was licensed and in operation prior to January 1, 1992;

495.1 (j) to license and certify new nursing home beds to replace beds in a facility acquired
495.2 by the Minneapolis Community Development Agency as part of redevelopment activities
495.3 in a city of the first class, provided the new facility is located within three miles of the site
495.4 of the old facility. Operating and property costs for the new facility must be determined and
495.5 allowed under section 256B.431 or 256B.434 or chapter 256R;

495.6 (k) to license and certify up to 20 new nursing home beds in a community-operated
495.7 hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991,
495.8 that suspended operation of the hospital in April 1986. The commissioner of human services
495.9 shall provide the facility with the same per diem property-related payment rate for each
495.10 additional licensed and certified bed as it will receive for its existing 40 beds;

495.11 (l) to license or certify beds in renovation, replacement, or upgrading projects as defined
495.12 in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's
495.13 remodeling projects do not exceed \$1,000,000;

495.14 (m) to license and certify beds that are moved from one location to another for the
495.15 purposes of converting up to five four-bed wards to single or double occupancy rooms in
495.16 a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity
495.17 of 115 beds;

495.18 (n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing
495.19 facility located in Minneapolis to layaway all of its licensed and certified nursing home
495.20 beds. These beds may be relicensed and recertified in a newly constructed teaching nursing
495.21 home facility affiliated with a teaching hospital upon approval by the legislature. The
495.22 proposal must be developed in consultation with the interagency committee on long-term
495.23 care planning. The beds on layaway status shall have the same status as voluntarily delicensed
495.24 and decertified beds, except that beds on layaway status remain subject to the surcharge in
495.25 section 256.9657. This layaway provision expires July 1, 1998;

495.26 (o) to allow a project which will be completed in conjunction with an approved
495.27 moratorium exception project for a nursing home in southern Cass County and which is
495.28 directly related to that portion of the facility that must be repaired, renovated, or replaced,
495.29 to correct an emergency plumbing problem for which a state correction order has been
495.30 issued and which must be corrected by August 31, 1993;

495.31 (p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing
495.32 facility located in Minneapolis to layaway, upon 30 days prior written notice to the
495.33 commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed
495.34 wards to single or double occupancy. Beds on layaway status shall have the same status as

496.1 voluntarily delicensed and decertified beds except that beds on layaway status remain subject
496.2 to the surcharge in section 256.9657, remain subject to the license application and renewal
496.3 fees under section 144A.07 and shall be subject to a \$100 per bed reactivation fee. In
496.4 addition, at any time within three years of the effective date of the layaway, the beds on
496.5 layaway status may be:

496.6 (1) relicensed and recertified upon relocation and reactivation of some or all of the beds
496.7 to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or
496.8 International Falls; provided that the total project construction costs related to the relocation
496.9 of beds from layaway status for any facility receiving relocated beds may not exceed the
496.10 dollar threshold provided in subdivision 2 unless the construction project has been approved
496.11 through the moratorium exception process under section 144A.073;

496.12 (2) relicensed and recertified, upon reactivation of some or all of the beds within the
496.13 facility which placed the beds in layaway status, if the commissioner has determined a need
496.14 for the reactivation of the beds on layaway status.

496.15 The property-related payment rate of a facility placing beds on layaway status must be
496.16 adjusted by the incremental change in its rental per diem after recalculating the rental per
496.17 diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
496.18 payment rate for a facility relicensing and recertifying beds from layaway status must be
496.19 adjusted by the incremental change in its rental per diem after recalculating its rental per
496.20 diem using the number of beds after the relicensing to establish the facility's capacity day
496.21 divisor, which shall be effective the first day of the month following the month in which
496.22 the relicensing and recertification became effective. Any beds remaining on layaway status
496.23 more than three years after the date the layaway status became effective must be removed
496.24 from layaway status and immediately delicensed and decertified;

496.25 (q) to license and certify beds in a renovation and remodeling project to convert 12
496.26 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing
496.27 home that, as of January 1, 1994, met the following conditions: the nursing home was located
496.28 in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the
496.29 top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total
496.30 project construction cost estimate for this project must not exceed the cost estimate submitted
496.31 in connection with the 1993 moratorium exception process;

496.32 (r) to license and certify up to 117 beds that are relocated from a licensed and certified
496.33 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds
496.34 located in South St. Paul, provided that the nursing facility and hospital are owned by the

497.1 same or a related organization and that prior to the date the relocation is completed the
497.2 hospital ceases operation of its inpatient hospital services at that hospital. After relocation,
497.3 the nursing facility's status shall be the same as it was prior to relocation. The nursing
497.4 facility's property-related payment rate resulting from the project authorized in this paragraph
497.5 shall become effective no earlier than April 1, 1996. For purposes of calculating the
497.6 incremental change in the facility's rental per diem resulting from this project, the allowable
497.7 appraised value of the nursing facility portion of the existing health care facility physical
497.8 plant prior to the renovation and relocation may not exceed \$2,490,000;

497.9 (s) to license and certify two beds in a facility to replace beds that were voluntarily
497.10 delicensed and decertified on June 28, 1991;

497.11 (t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing
497.12 home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure
497.13 and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home
497.14 facility after completion of a construction project approved in 1993 under section 144A.073,
497.15 to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway
497.16 status shall have the same status as voluntarily delicensed or decertified beds except that
497.17 they shall remain subject to the surcharge in section 256.9657. The 16 beds on layaway
497.18 status may be relicensed as nursing home beds and recertified at any time within five years
497.19 of the effective date of the layaway upon relocation of some or all of the beds to a licensed
497.20 and certified facility located in Watertown, provided that the total project construction costs
497.21 related to the relocation of beds from layaway status for the Watertown facility may not
497.22 exceed the dollar threshold provided in subdivision 2 unless the construction project has
497.23 been approved through the moratorium exception process under section 144A.073.

497.24 The property-related payment rate of the facility placing beds on layaway status must
497.25 be adjusted by the incremental change in its rental per diem after recalculating the rental
497.26 per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related
497.27 payment rate for the facility relicensing and recertifying beds from layaway status must be
497.28 adjusted by the incremental change in its rental per diem after recalculating its rental per
497.29 diem using the number of beds after the relicensing to establish the facility's capacity day
497.30 divisor, which shall be effective the first day of the month following the month in which
497.31 the relicensing and recertification became effective. Any beds remaining on layaway status
497.32 more than five years after the date the layaway status became effective must be removed
497.33 from layaway status and immediately delicensed and decertified;

497.34 (u) to license and certify beds that are moved within an existing area of a facility or to
497.35 a newly constructed addition which is built for the purpose of eliminating three- and four-bed

498.1 rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas
498.2 in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed
498.3 capacity of 129 beds;

498.4 (v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to
498.5 a 160-bed facility in Crow Wing County, provided all the affected beds are under common
498.6 ownership;

498.7 (w) to license and certify a total replacement project of up to 49 beds located in Norman
498.8 County that are relocated from a nursing home destroyed by flood and whose residents were
498.9 relocated to other nursing homes. The operating cost payment rates for the new nursing
498.10 facility shall be determined based on the interim and settle-up payment provisions of
498.11 Minnesota Rules, part 9549.0057, and the reimbursement provisions of ~~section 256B.431~~
498.12 chapter 256R. Property-related reimbursement rates shall be determined under section
498.13 ~~256B.431~~ 256R.26, taking into account any federal or state flood-related loans or grants
498.14 provided to the facility;

498.15 (x) to license and certify to the licensee of a nursing home in Polk County that was
498.16 destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least
498.17 25 beds to be located in Polk County and up to 104 beds distributed among up to three other
498.18 counties. These beds may only be distributed to counties with fewer than the median number
498.19 of age intensity adjusted beds per thousand, as most recently published by the commissioner
498.20 of human services. If the licensee chooses to distribute beds outside of Polk County under
498.21 this paragraph, prior to distributing the beds, the commissioner of health must approve the
498.22 location in which the licensee plans to distribute the beds. The commissioner of health shall
498.23 consult with the commissioner of human services prior to approving the location of the
498.24 proposed beds. The licensee may combine these beds with beds relocated from other nursing
498.25 facilities as provided in section 144A.073, subdivision 3c. The operating payment rates for
498.26 the new nursing facilities shall be determined based on the interim and settle-up payment
498.27 provisions of ~~section 256B.431, 256B.434, or 256B.441~~ or Minnesota Rules, parts 9549.0010
498.28 to 9549.0080. Property-related reimbursement rates shall be determined under section
498.29 ~~256B.431, 256B.434, or 256B.441~~ 256R.26. If the replacement beds permitted under this
498.30 paragraph are combined with beds from other nursing facilities, the rates shall be calculated
498.31 as the weighted average of rates determined as provided in this paragraph and section
498.32 ~~256B.441, subdivision 60~~ 256R.50;

498.33 (y) to license and certify beds in a renovation and remodeling project to convert 13
498.34 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add
498.35 improvements in a nursing home that, as of January 1, 1994, met the following conditions:

499.1 the nursing home was located in Ramsey County, was not owned by a hospital corporation,
499.2 had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by
499.3 the 1993 moratorium exceptions advisory review panel. The total project construction cost
499.4 estimate for this project must not exceed the cost estimate submitted in connection with the
499.5 1993 moratorium exception process;

499.6 (z) to license and certify up to 150 nursing home beds to replace an existing 285 bed
499.7 nursing facility located in St. Paul. The replacement project shall include both the renovation
499.8 of existing buildings and the construction of new facilities at the existing site. The reduction
499.9 in the licensed capacity of the existing facility shall occur during the construction project
499.10 as beds are taken out of service due to the construction process. Prior to the start of the
499.11 construction process, the facility shall provide written information to the commissioner of
499.12 health describing the process for bed reduction, plans for the relocation of residents, and
499.13 the estimated construction schedule. The relocation of residents shall be in accordance with
499.14 the provisions of law and rule;

499.15 (aa) to allow the commissioner of human services to license an additional 36 beds to
499.16 provide residential services for the physically disabled under Minnesota Rules, parts
499.17 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that
499.18 the total number of licensed and certified beds at the facility does not increase;

499.19 (bb) to license and certify a new facility in St. Louis County with 44 beds constructed
499.20 to replace an existing facility in St. Louis County with 31 beds, which has resident rooms
499.21 on two separate floors and an antiquated elevator that creates safety concerns for residents
499.22 and prevents nonambulatory residents from residing on the second floor. The project shall
499.23 include the elimination of three- and four-bed rooms;

499.24 (cc) to license and certify four beds in a 16-bed certified boarding care home in
499.25 Minneapolis to replace beds that were voluntarily delicensed and decertified on or before
499.26 March 31, 1992. The licensure and certification is conditional upon the facility periodically
499.27 assessing and adjusting its resident mix and other factors which may contribute to a potential
499.28 institution for mental disease declaration. The commissioner of human services shall retain
499.29 the authority to audit the facility at any time and shall require the facility to comply with
499.30 any requirements necessary to prevent an institution for mental disease declaration, including
499.31 delicensure and decertification of beds, if necessary;

499.32 (dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80
499.33 beds as part of a renovation project. The renovation must include construction of an addition
499.34 to accommodate ten residents with beginning and midstage dementia in a self-contained

500.1 living unit; creation of three resident households where dining, activities, and support spaces
500.2 are located near resident living quarters; designation of four beds for rehabilitation in a
500.3 self-contained area; designation of 30 private rooms; and other improvements;

500.4 (ee) to license and certify beds in a facility that has undergone replacement or remodeling
500.5 as part of a planned closure under section ~~256B.437~~ 256R.40;

500.6 (ff) to license and certify a total replacement project of up to 124 beds located in Wilkin
500.7 County that are in need of relocation from a nursing home significantly damaged by flood.
500.8 The operating cost payment rates for the new nursing facility shall be determined based on
500.9 the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the
500.10 reimbursement provisions of ~~section 256B.431~~ chapter 256R. Property-related reimbursement
500.11 rates shall be determined under section ~~256B.431~~ 256R.26, taking into account any federal
500.12 or state flood-related loans or grants provided to the facility;

500.13 (gg) to allow the commissioner of human services to license an additional nine beds to
500.14 provide residential services for the physically disabled under Minnesota Rules, parts
500.15 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the
500.16 total number of licensed and certified beds at the facility does not increase;

500.17 (hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility
500.18 in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new
500.19 facility is located within four miles of the existing facility and is in Anoka County. Operating
500.20 and property rates shall be determined and allowed under ~~section 256B.431~~ chapter 256R
500.21 and Minnesota Rules, parts 9549.0010 to 9549.0080, ~~or section 256B.434 or 256B.441~~; or

500.22 (ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that,
500.23 as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit
500.24 nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective
500.25 when the receiving facility notifies the commissioner in writing of the number of beds
500.26 accepted. The commissioner shall place all transferred beds on layaway status held in the
500.27 name of the receiving facility. The layaway adjustment provisions of section 256B.431,
500.28 subdivision 30, do not apply to this layaway. The receiving facility may only remove the
500.29 beds from layaway for recertification and relicensure at the receiving facility's current site,
500.30 or at a newly constructed facility located in Anoka County. The receiving facility must
500.31 receive statutory authorization before removing these beds from layaway status, or may
500.32 remove these beds from layaway status if removal from layaway status is part of a
500.33 moratorium exception project approved by the commissioner under section 144A.073.

501.1 Sec. 7. Minnesota Statutes 2016, section 144A.071, subdivision 4c, is amended to read:

501.2 Subd. 4c. **Exceptions for replacement beds after June 30, 2003.** (a) The commissioner
501.3 of health, in coordination with the commissioner of human services, may approve the
501.4 renovation, replacement, upgrading, or relocation of a nursing home or boarding care home,
501.5 under the following conditions:

501.6 (1) to license and certify an 80-bed city-owned facility in Nicollet County to be
501.7 constructed on the site of a new city-owned hospital to replace an existing 85-bed facility
501.8 attached to a hospital that is also being replaced. The threshold allowed for this project
501.9 under section 144A.073 shall be the maximum amount available to pay the additional
501.10 medical assistance costs of the new facility;

501.11 (2) to license and certify 29 beds to be added to an existing 69-bed facility in St. Louis
501.12 County, provided that the 29 beds must be transferred from active or layaway status at an
501.13 existing facility in St. Louis County that had 235 beds on April 1, 2003.

501.14 The licensed capacity at the 235-bed facility must be reduced to 206 beds, but the payment
501.15 rate at that facility shall not be adjusted as a result of this transfer. The operating payment
501.16 rate of the facility adding beds after completion of this project shall be the same as it was
501.17 on the day prior to the day the beds are licensed and certified. This project shall not proceed
501.18 unless it is approved and financed under the provisions of section 144A.073;

501.19 (3) to license and certify a new 60-bed facility in Austin, provided that: (i) 45 of the new
501.20 beds are transferred from a 45-bed facility in Austin under common ownership that is closed
501.21 and 15 of the new beds are transferred from a 182-bed facility in Albert Lea under common
501.22 ownership; (ii) the commissioner of human services is authorized by the 2004 legislature
501.23 to negotiate budget-neutral planned nursing facility closures; and (iii) money is available
501.24 from planned closures of facilities under common ownership to make implementation of
501.25 this clause budget-neutral to the state. The bed capacity of the Albert Lea facility shall be
501.26 reduced to 167 beds following the transfer. Of the 60 beds at the new facility, 20 beds shall
501.27 be used for a special care unit for persons with Alzheimer's disease or related dementias;

501.28 (4) to license and certify up to 80 beds transferred from an existing state-owned nursing
501.29 facility in Cass County to a new facility located on the grounds of the Ah-Gwah-Ching
501.30 campus. The operating cost payment rates for the new facility shall be determined based
501.31 on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and
501.32 the reimbursement provisions of ~~section 256B.431~~ chapter 256R. The property payment
501.33 rate for the first three years of operation shall be \$35 per day. For subsequent years, the
501.34 property payment rate of \$35 per day shall be adjusted for inflation as provided in section

502.1 256B.434, subdivision 4, paragraph (c), as long as the facility has a contract under section
502.2 256B.434;

502.3 (5) to initiate a pilot program to license and certify up to 80 beds transferred from an
502.4 existing county-owned nursing facility in Steele County relocated to the site of a new acute
502.5 care facility as part of the county's Communities for a Lifetime comprehensive plan to create
502.6 innovative responses to the aging of its population. Upon relocation to the new site, the
502.7 nursing facility shall delicense 28 beds. The payment rate for external fixed costs for the
502.8 new facility shall be increased by an amount as calculated according to items (i) to (v):

502.9 (i) compute the estimated decrease in medical assistance residents served by the nursing
502.10 facility by multiplying the decrease in licensed beds by the historical percentage of medical
502.11 assistance resident days;

502.12 (ii) compute the annual savings to the medical assistance program from the delicensure
502.13 of 28 beds by multiplying the anticipated decrease in medical assistance residents, determined
502.14 in item (i), by the existing facility's weighted average payment rate multiplied by 365;

502.15 (iii) compute the anticipated annual costs for community-based services by multiplying
502.16 the anticipated decrease in medical assistance residents served by the nursing facility,
502.17 determined in item (i), by the average monthly elderly waiver service costs for individuals
502.18 in Steele County multiplied by 12;

502.19 (iv) subtract the amount in item (iii) from the amount in item (ii);

502.20 (v) divide the amount in item (iv) by an amount equal to the relocated nursing facility's
502.21 occupancy factor under section 256B.431, subdivision 3f, paragraph (c), multiplied by the
502.22 historical percentage of medical assistance resident days; and

502.23 (6) to consolidate and relocate nursing facility beds to a new site in Goodhue County
502.24 and to integrate these services with other community-based programs and services under a
502.25 communities for a lifetime pilot program and comprehensive plan to create innovative
502.26 responses to the aging of its population. Two nursing facilities, one for 84 beds and one for
502.27 65 beds, in the city of Red Wing licensed on July 1, 2015, shall be consolidated into a newly
502.28 renovated 64-bed nursing facility resulting in the delicensure of 85 beds. Notwithstanding
502.29 the carryforward of the approval authority in section 144A.073, subdivision 11, the funding
502.30 approved in April 2009 by the commissioner of health for a project in Goodhue County
502.31 shall not carry forward. The closure of the 85 beds shall not be eligible for a planned closure
502.32 rate adjustment under section ~~256B.437~~ 256R.40. The construction project permitted in this
502.33 clause shall not be eligible for a threshold project rate adjustment under section 256B.434,

503.1 subdivision 4f. The payment rate for external fixed costs for the new facility shall be
503.2 increased by an amount as calculated according to items (i) to (vi):

503.3 (i) compute the estimated decrease in medical assistance residents served by both nursing
503.4 facilities by multiplying the difference between the occupied beds of the two nursing facilities
503.5 for the reporting year ending September 30, 2009, and the projected occupancy of the facility
503.6 at 95 percent occupancy by the historical percentage of medical assistance resident days;

503.7 (ii) compute the annual savings to the medical assistance program from the delicensure
503.8 by multiplying the anticipated decrease in the medical assistance residents, determined in
503.9 item (i), by the hospital-owned nursing facility weighted average payment rate multiplied
503.10 by 365;

503.11 (iii) compute the anticipated annual costs for community-based services by multiplying
503.12 the anticipated decrease in medical assistance residents served by the facilities, determined
503.13 in item (i), by the average monthly elderly waiver service costs for individuals in Goodhue
503.14 County multiplied by 12;

503.15 (iv) subtract the amount in item (iii) from the amount in item (ii);

503.16 (v) multiply the amount in item (iv) by 57.2 percent; and

503.17 (vi) divide the difference of the amount in item (iv) and the amount in item (v) by an
503.18 amount equal to the relocated nursing facility's occupancy factor under section 256B.431,
503.19 subdivision 3f, paragraph (c), multiplied by the historical percentage of medical assistance
503.20 resident days.

503.21 (b) Projects approved under this subdivision shall be treated in a manner equivalent to
503.22 projects approved under subdivision 4a.

503.23 Sec. 8. Minnesota Statutes 2016, section 144A.071, subdivision 4d, is amended to read:

503.24 Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in
503.25 consultation with the commissioner of human services, may approve a request for
503.26 consolidation of nursing facilities which includes the closure of one or more facilities and
503.27 the upgrading of the physical plant of the remaining nursing facility or facilities, the costs
503.28 of which exceed the threshold project limit under subdivision 2, clause (a). The
503.29 commissioners shall consider the criteria in this section, section 144A.073, and section
503.30 ~~256B.437~~ 256R.40, in approving or rejecting a consolidation proposal. In the event the
503.31 commissioners approve the request, the commissioner of human services shall calculate an
503.32 external fixed costs rate adjustment according to clauses (1) to (3):

504.1 (1) the closure of beds shall not be eligible for a planned closure rate adjustment under
504.2 section ~~256B.437, subdivision 6~~ 256R.40, subdivision 5;

504.3 (2) the construction project permitted in this clause shall not be eligible for a threshold
504.4 project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception
504.5 adjustment under section 144A.073; and

504.6 (3) the payment rate for external fixed costs for a remaining facility or facilities shall
504.7 be increased by an amount equal to 65 percent of the projected net cost savings to the state
504.8 calculated in paragraph (b), divided by the state's medical assistance percentage of medical
504.9 assistance dollars, and then divided by estimated medical assistance resident days, as
504.10 determined in paragraph (c), of the remaining nursing facility or facilities in the request in
504.11 this paragraph. The rate adjustment is effective on the later of the first day of the month
504.12 following completion of the construction upgrades in the consolidation plan or the first day
504.13 of the month following the complete closure of a facility designated for closure in the
504.14 consolidation plan. If more than one facility is receiving upgrades in the consolidation plan,
504.15 each facility's date of construction completion must be evaluated separately.

504.16 (b) For purposes of calculating the net cost savings to the state, the commissioner shall
504.17 consider clauses (1) to (7):

504.18 (1) the annual savings from estimated medical assistance payments from the net number
504.19 of beds closed taking into consideration only beds that are in active service on the date of
504.20 the request and that have been in active service for at least three years;

504.21 (2) the estimated annual cost of increased case load of individuals receiving services
504.22 under the elderly waiver;

504.23 (3) the estimated annual cost of elderly waiver recipients receiving support under group
504.24 residential housing;

504.25 (4) the estimated annual cost of increased case load of individuals receiving services
504.26 under the alternative care program;

504.27 (5) the annual loss of license surcharge payments on closed beds;

504.28 (6) the savings from not paying planned closure rate adjustments that the facilities would
504.29 otherwise be eligible for under section ~~256B.437~~ 256R.40; and

504.30 (7) the savings from not paying external fixed costs payment rate adjustments from
504.31 submission of renovation costs that would otherwise be eligible as threshold projects under
504.32 section 256B.434, subdivision 4f.

505.1 (c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical
505.2 assistance resident days of the remaining facility or facilities shall be computed assuming
505.3 95 percent occupancy multiplied by the historical percentage of medical assistance resident
505.4 days of the remaining facility or facilities, as reported on the facility's or facilities' most
505.5 recent nursing facility statistical and cost report filed before the plan of closure is submitted,
505.6 multiplied by 365.

505.7 (d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy
505.8 percentages will be those reported on the facility's or facilities' most recent nursing facility
505.9 statistical and cost report filed before the plan of closure is submitted, and the average
505.10 payment rates shall be calculated based on the approved payment rates in effect at the time
505.11 the consolidation request is submitted.

505.12 (e) To qualify for the external fixed costs payment rate adjustment under this subdivision,
505.13 the closing facilities shall:

505.14 (1) submit an application for closure according to section ~~256B.437, subdivision 3~~
505.15 256R.40, subdivision 2; and

505.16 (2) follow the resident relocation provisions of section 144A.161.

505.17 (f) The county or counties in which a facility or facilities are closed under this subdivision
505.18 shall not be eligible for designation as a hardship area under subdivision 3 for five years
505.19 from the date of the approval of the proposed consolidation. The applicant shall notify the
505.20 county of this limitation and the county shall acknowledge this in a letter of support.

505.21 Sec. 9. Minnesota Statutes 2016, section 144A.073, subdivision 3c, is amended to read:

505.22 Subd. 3c. **Cost neutral relocation projects.** (a) Notwithstanding subdivision 3, the
505.23 commissioner may at any time accept proposals, or amendments to proposals previously
505.24 approved under this section, for relocations that are cost neutral with respect to state costs
505.25 as defined in section 144A.071, subdivision 5a. The commissioner, in consultation with the
505.26 commissioner of human services, shall evaluate proposals according to subdivision 4a,
505.27 clauses (1), (4), (5), (6), and (8), and other criteria established in rule or law. The
505.28 commissioner of human services shall determine the allowable payment rates of the facility
505.29 receiving the beds in accordance with section ~~256B.441, subdivision 60~~ 256R.50. The
505.30 commissioner shall approve or disapprove a project within 90 days.

505.31 (b) For the purposes of paragraph (a), cost neutrality shall be measured over the first
505.32 three 12-month periods of operation after completion of the project.

506.1 Sec. 10. Minnesota Statutes 2016, section 144A.10, subdivision 4, is amended to read:

506.2 Subd. 4. **Correction orders.** Whenever a duly authorized representative of the
506.3 commissioner of health finds upon inspection of a nursing home, that the facility or a
506.4 controlling person or an employee of the facility is not in compliance with sections 144.411
506.5 to 144.417, 144.651, 144.6503, 144A.01 to 144A.155, or 626.557 or the rules promulgated
506.6 thereunder, a correction order shall be issued to the facility. The correction order shall state
506.7 the deficiency, cite the specific rule or statute violated, state the suggested method of
506.8 correction, and specify the time allowed for correction. If the commissioner finds that the
506.9 nursing home had uncorrected or repeated violations which create a risk to resident care,
506.10 safety, or rights, the commissioner shall notify the commissioner of human services ~~who~~
506.11 ~~shall require the facility to use any efficiency incentive payments received under section~~
506.12 ~~256B.431, subdivision 2b, paragraph (d), to correct the violations and shall require the~~
506.13 ~~facility to forfeit incentive payments for failure to correct the violations as provided in~~
506.14 ~~section 256B.431, subdivision 2n. The forfeiture shall not apply to correction orders issued~~
506.15 ~~for physical plant deficiencies.~~

506.16 Sec. 11. Minnesota Statutes 2016, section 144A.15, subdivision 2, is amended to read:

506.17 Subd. 2. **Appointment of receiver, rental.** If, after hearing, the court finds that
506.18 receivership is necessary as a means of protecting the health, safety, or welfare of a resident
506.19 of the facility, the court shall appoint the commissioner of health as a receiver to take charge
506.20 of the facility. The commissioner may enter into an agreement for a managing agent to work
506.21 on the commissioner's behalf in operating the facility during the receivership. The court
506.22 shall determine a fair monthly rental for the facility, taking into account all relevant factors
506.23 including the condition of the facility. This rental fee shall be paid by the receiver to the
506.24 appropriate controlling person for each month that the receivership remains in effect but
506.25 shall be reduced by the amount that the costs of the receivership provided under section
506.26 ~~256B.495~~ 256R.52 are in excess of the facility rate. The controlling person may agree to
506.27 waive the fair monthly rent by affidavit to the court. Notwithstanding any other law to the
506.28 contrary, no payment made to a controlling person by any state agency during a period of
506.29 receivership shall include any allowance for profit or be based on any formula which includes
506.30 an allowance for profit.

506.31 Notwithstanding state contracting requirements in chapter 16C, the commissioner shall
506.32 establish and maintain a list of qualified licensed nursing home administrators, or other
506.33 qualified persons or organizations with experience in delivering skilled health care services
506.34 and the operation of long-term care facilities for those interested in being a managing agent

507.1 on the commissioner's behalf during a state receivership of a facility. This list will be a
507.2 resource for choosing a managing agent and the commissioner may update the list at any
507.3 time. A managing agent cannot be someone who: (1) is the owner, licensee, or administrator
507.4 of the facility; (2) has a financial interest in the facility at the time of the receivership or is
507.5 a related party to the owner, licensee, or administrator; or (3) has owned or operated any
507.6 nursing facility or boarding care home that has been ordered into receivership.

507.7 Sec. 12. Minnesota Statutes 2016, section 144A.154, is amended to read:

507.8 **144A.154 RATE RECOMMENDATION.**

507.9 The commissioner may recommend to the commissioner of human services a review of
507.10 the rates for a nursing home or boarding care home that participates in the medical assistance
507.11 program that is in voluntary or involuntary receivership, and that has needs or deficiencies
507.12 documented by the Department of Health. If the commissioner of health determines that a
507.13 review of the rate under section ~~256B.495~~ 256R.52 is needed, the commissioner shall provide
507.14 the commissioner of human services with:

507.15 (1) a copy of the order or determination that cites the deficiency or need; and

507.16 (2) the commissioner's recommendation for additional staff and additional annual hours
507.17 by type of employee and additional consultants, services, supplies, equipment, or repairs
507.18 necessary to satisfy the need or deficiency.

507.19 Sec. 13. Minnesota Statutes 2016, section 144A.161, subdivision 10, is amended to read:

507.20 Subd. 10. **Facility closure rate adjustment.** Upon the request of a closing facility, the
507.21 commissioner of human services must allow the facility a closure rate adjustment equal to
507.22 a 50 percent payment rate increase to reimburse relocation costs or other costs related to
507.23 facility closure. This rate increase is effective on the date the facility's occupancy decreases
507.24 to 90 percent of capacity days after the written notice of closure is distributed under
507.25 subdivision 5 and shall remain in effect for a period of up to 60 days. The commissioner
507.26 shall delay the implementation of rate adjustments under section ~~256B.437, subdivisions~~
507.27 ~~3, paragraph (b), and 6, paragraph (a)~~ 256R.40, subdivisions 5 and 6, to offset the cost of
507.28 this rate adjustment.

507.29 Sec. 14. Minnesota Statutes 2016, section 144A.1888, is amended to read:

507.30 **144A.1888 REUSE OF FACILITIES.**

508.1 Notwithstanding any local ordinance related to development, planning, or zoning to the
508.2 contrary, the conversion or reuse of a nursing home that closes or that curtails, reduces, or
508.3 changes operations shall be considered a conforming use permitted under local law, provided
508.4 that the facility is converted to another long-term care service approved by a regional
508.5 planning group under section ~~256B.437~~ 256R.40 that serves a smaller number of persons
508.6 than the number of persons served before the closure or curtailment, reduction, or change
508.7 in operations.

508.8 Sec. 15. Minnesota Statutes 2016, section 144A.611, subdivision 1, is amended to read:

508.9 Subdivision 1. **Nursing homes and certified boarding care homes.** The actual costs
508.10 of tuition and textbooks and reasonable expenses for the competency evaluation or the
508.11 nursing assistant training program and competency evaluation approved under section
508.12 144A.61, which are paid to nursing assistants or adult training programs pursuant to
508.13 subdivisions 2 and 4, are a reimbursable expense for nursing homes and certified boarding
508.14 care homes under section ~~256B.431, subdivision 36~~ 256R.37.

508.15 Sec. 16. Minnesota Statutes 2016, section 144A.74, is amended to read:

508.16 **144A.74 MAXIMUM CHARGES.**

508.17 A supplemental nursing services agency must not bill or receive payments from a nursing
508.18 home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted
508.19 average wage rate, plus a factor determined by the commissioner to incorporate payroll
508.20 taxes as defined in ~~Minnesota Rules, part 9549.0020, subpart 33~~ section 256R.02, subdivision
508.21 37, for the applicable employee classification for the geographic group to which the nursing
508.22 home is assigned under Minnesota Rules, part 9549.0052. The weighted average wage rates
508.23 must be determined by the commissioner of human services and reported to the commissioner
508.24 of health on an annual basis. Wages are defined as hourly rate of pay and shift differential,
508.25 including weekend shift differential and overtime. Facilities shall provide information
508.26 necessary to determine weighted average wage rates to the commissioner of human services
508.27 in a format requested by the commissioner. The maximum rate must include all charges for
508.28 administrative fees, contract fees, or other special charges in addition to the hourly rates for
508.29 the temporary nursing pool personnel supplied to a nursing home.

508.30 Sec. 17. Minnesota Statutes 2016, section 256.9657, subdivision 1, is amended to read:

508.31 Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each
508.32 non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner

509.1 an annual surcharge according to the schedule in subdivision 4. The surcharge shall be
509.2 calculated as \$620 per licensed bed. If the number of licensed beds is reduced, the surcharge
509.3 shall be based on the number of remaining licensed beds the second month following the
509.4 receipt of timely notice by the commissioner of human services that beds have been
509.5 delicensed. The nursing home must notify the commissioner of health in writing when beds
509.6 are delicensed. The commissioner of health must notify the commissioner of human services
509.7 within ten working days after receiving written notification. If the notification is received
509.8 by the commissioner of human services by the 15th of the month, the invoice for the second
509.9 following month must be reduced to recognize the delicensing of beds. Beds on layaway
509.10 status continue to be subject to the surcharge. The commissioner of human services must
509.11 acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal
509.12 from the provider.

509.13 (b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to \$625.

509.14 (c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to
509.15 \$990.

509.16 (d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to
509.17 \$2,815.

509.18 (e) The commissioner may reduce, and may subsequently restore, the surcharge under
509.19 paragraph (d) based on the commissioner's determination of a permissible surcharge.

509.20 ~~(f) Between April 1, 2002, and August 15, 2004, a facility governed by this subdivision~~
509.21 ~~may elect to assume full participation in the medical assistance program by agreeing to~~
509.22 ~~comply with all of the requirements of the medical assistance program, including the rate~~
509.23 ~~equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements~~
509.24 ~~established in law or rule, and to begin intake of new medical assistance recipients. Rates~~
509.25 ~~will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. Rate calculations~~
509.26 ~~will be subject to limits as prescribed in rule and law. Other than the adjustments in sections~~
509.27 ~~256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota~~
509.28 ~~Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization~~
509.29 ~~of rates, facilities assuming full participation in medical assistance under this paragraph are~~
509.30 ~~not eligible for any rate adjustments until the July 1 following their settle-up period.~~

509.31 Sec. 18. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

509.32 Subd. 3e. **Customized living service rate.** (a) Payment for customized living services
509.33 shall be a monthly rate authorized by the lead agency within the parameters established by

510.1 the commissioner. The payment agreement must delineate the amount of each component
510.2 service included in the recipient's customized living service plan. The lead agency, with
510.3 input from the provider of customized living services, shall ensure that there is a documented
510.4 need within the parameters established by the commissioner for all component customized
510.5 living services authorized.

510.6 (b) The payment rate must be based on the amount of component services to be provided
510.7 utilizing component rates established by the commissioner. Counties and tribes shall use
510.8 tools issued by the commissioner to develop and document customized living service plans
510.9 and rates.

510.10 (c) Component service rates must not exceed payment rates for comparable elderly
510.11 waiver or medical assistance services and must reflect economies of scale. Customized
510.12 living services must not include rent or raw food costs.

510.13 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
510.14 individualized monthly authorized payment for the customized living service plan shall not
510.15 exceed 50 percent of the greater of either the statewide or any of the geographic groups'
510.16 weighted average monthly nursing facility rate of the case mix resident class to which the
510.17 elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051
510.18 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph
510.19 (a). Effective on July 1 of the state fiscal year in which the resident assessment system as
510.20 described in section ~~256B.438~~ 256R.17 for nursing home rate determination is implemented
510.21 and July 1 of each subsequent state fiscal year, the individualized monthly authorized
510.22 payment for the services described in this clause shall not exceed the limit which was in
510.23 effect on June 30 of the previous state fiscal year updated annually based on legislatively
510.24 adopted changes to all service rate maximums for home and community-based service
510.25 providers.

510.26 (e) Effective July 1, 2011, the individualized monthly payment for the customized living
510.27 service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly
510.28 authorized payment limit for customized living for individuals classified as case mix A,
510.29 reduced by 25 percent. This rate limit must be applied to all new participants enrolled in
510.30 the program on or after July 1, 2011, who meet the criteria described in subdivision 3a,
510.31 paragraph (b). This monthly limit also applies to all other participants who meet the criteria
510.32 described in subdivision 3a, paragraph (b), at reassessment.

510.33 (f) Customized living services are delivered by a provider licensed by the Department
510.34 of Health as a class A or class F home care provider and provided in a building that is

511.1 registered as a housing with services establishment under chapter 144D. Licensed home
511.2 care providers are subject to section 256B.0651, subdivision 14.

511.3 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
511.4 family for additional units of any allowable component service beyond those available under
511.5 the service rate limits described in paragraph (d), nor for additional units of any allowable
511.6 component service beyond those approved in the service plan by the lead agency.

511.7 (h) Effective July 1, 2016, and each July 1 thereafter, individualized service rate limits
511.8 for customized living services under this subdivision shall be increased by the difference
511.9 between any legislatively adopted home and community-based provider rate increases
511.10 effective on July 1 or since the previous July 1 and the average statewide percentage increase
511.11 in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~
511.12 chapter 256R, effective the previous January 1. This paragraph shall only apply if the average
511.13 statewide percentage increase in nursing facility operating payment rates is greater than any
511.14 legislatively adopted home and community-based provider rate increases effective on July
511.15 1, or occurring since the previous July 1.

511.16 Sec. 19. Minnesota Statutes 2016, section 256B.35, subdivision 4, is amended to read:

511.17 Subd. 4. **Field audits required.** The commissioner of human services shall conduct
511.18 field audits at the same time as cost report audits required under section ~~256B.27, subdivision~~
511.19 ~~2a~~ 256R.13, subdivision 1, and at any other time but at least once every four years, without
511.20 notice, to determine whether this section was complied with and that the funds provided
511.21 residents for their personal needs were actually expended for that purpose.

511.22 Sec. 20. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

511.23 Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July
511.24 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway
511.25 shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph
511.26 (c), and calculation of the rental per diem, have those beds given the same effect as if the
511.27 beds had been delicensed so long as the beds remain on layaway. At the time of a layaway,
511.28 a facility may change its single bed election for use in calculating capacity days under
511.29 Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be
511.30 effective the first day of the month following the month in which the layaway of the beds
511.31 becomes effective under section 144A.071, subdivision 4b.

511.32 (b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to
511.33 the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under

512.1 that section or chapter which has placed beds on layaway shall, for so long as the beds
512.2 remain on layaway, be allowed to:

512.3 (1) aggregate the applicable investment per bed limits based on the number of beds
512.4 licensed immediately prior to entering the alternative payment system;

512.5 (2) retain or change the facility's single bed election for use in calculating capacity days
512.6 under Minnesota Rules, part 9549.0060, subpart 11; and

512.7 (3) establish capacity days based on the number of beds immediately prior to the layaway
512.8 and the number of beds after the layaway.

512.9 The commissioner shall increase the facility's property payment rate by the incremental
512.10 increase in the rental per diem resulting from the recalculation of the facility's rental per
512.11 diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and
512.12 (3). If a facility reimbursed under section 256B.434 or chapter 256R completes a moratorium
512.13 exception project after its base year, the base year property rate shall be the moratorium
512.14 project property rate. The base year rate shall be inflated by the factors in section 256B.434,
512.15 subdivision 4, paragraph (c). The property payment rate increase shall be effective the first
512.16 day of the month following the month in which the layaway of the beds becomes effective.

512.17 (c) If a nursing facility removes a bed from layaway status in accordance with section
512.18 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the
512.19 number of licensed and certified beds in the facility not on layaway and shall reduce the
512.20 nursing facility's property payment rate in accordance with paragraph (b).

512.21 (d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision
512.22 to the contrary under section 256B.434 or chapter 256R, a nursing facility reimbursed under
512.23 that section or chapter, which has delicensed beds after July 1, 2000, by giving notice of
512.24 the delicensure to the commissioner of health according to the notice requirements in section
512.25 144A.071, subdivision 4b, shall be allowed to:

512.26 (1) aggregate the applicable investment per bed limits based on the number of beds
512.27 licensed immediately prior to entering the alternative payment system;

512.28 (2) retain or change the facility's single bed election for use in calculating capacity days
512.29 under Minnesota Rules, part 9549.0060, subpart 11; and

512.30 (3) establish capacity days based on the number of beds immediately prior to the
512.31 delicensure and the number of beds after the delicensure.

512.32 The commissioner shall increase the facility's property payment rate by the incremental
512.33 increase in the rental per diem resulting from the recalculation of the facility's rental per

513.1 diem applying only the changes resulting from the delicensure of beds and clauses (1), (2),
 513.2 and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
 513.3 project after its base year, the base year property rate shall be the moratorium project property
 513.4 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
 513.5 paragraph (c). The property payment rate increase shall be effective the first day of the
 513.6 month following the month in which the delicensure of the beds becomes effective.

513.7 (e) For nursing facilities reimbursed under this section ~~or~~ section 256B.434, or chapter
 513.8 256R, any beds placed on layaway shall not be included in calculating facility occupancy
 513.9 as it pertains to leave days defined in Minnesota Rules, part 9505.0415.

513.10 (f) For nursing facilities reimbursed under this section ~~or~~ section 256B.434, or chapter
 513.11 256R, the rental rate calculated after placing beds on layaway may not be less than the rental
 513.12 rate prior to placing beds on layaway.

513.13 (g) A nursing facility receiving a rate adjustment as a result of this section shall comply
 513.14 with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

513.15 (h) A facility that does not utilize the space made available as a result of bed layaway
 513.16 or delicensure under this subdivision to reduce the number of beds per room or provide
 513.17 more common space for nursing facility uses or perform other activities related to the
 513.18 operation of the nursing facility shall have its property rate increase calculated under this
 513.19 subdivision reduced by the ratio of the square footage made available that is not used for
 513.20 these purposes to the total square footage made available as a result of bed layaway or
 513.21 delicensure.

513.22 Sec. 21. Minnesota Statutes 2016, section 256B.50, subdivision 1, is amended to read:

513.23 Subdivision 1. **Scope.** A provider may appeal from a determination of a payment rate
 513.24 established pursuant to this chapter or allowed costs under ~~section 256B.441~~ chapter 256R
 513.25 if the appeal, if successful, would result in a change to the provider's payment rate or to the
 513.26 calculation of maximum charges to therapy vendors as provided by section ~~256B.433,~~
 513.27 ~~subdivision 3~~ 256R.54. Appeals must be filed in accordance with procedures in this section.
 513.28 This section does not apply to a request from a resident or long-term care facility for
 513.29 reconsideration of the classification of a resident under section 144.0722.

513.30 Sec. 22. **EFFECTIVE DATE.**

513.31 Sections 1 to 21 are effective the day following final enactment.

514.1 **ARTICLE 15**514.2 **HUMAN SERVICES FORECAST ADJUSTMENTS**514.3 Section 1. **DEPARTMENT OF HUMAN SERVICES FORECAST ADJUSTMENT.**

514.4 The dollar amounts shown are added to or, if shown in parentheses, are subtracted from
 514.5 the appropriations in Laws 2015, chapter 71, article 14, as amended by Laws 2016, chapter
 514.6 189, articles 22 and 23, from the general fund, or any other fund named, to the Department
 514.7 of Human Services for the purposes specified in this article, to be available for the fiscal
 514.8 years indicated for each purpose. The figure "2017" used in this article means that the
 514.9 appropriations listed are available for the fiscal year ending June 30, 2017.

514.10 **APPROPRIATIONS**
 514.11 **Available for the Year**
 514.12 **Ending June 30**
 514.13 **2017**

514.14 **Sec. 2. COMMISSIONER OF HUMAN**
 514.15 **SERVICES**

514.16 **Subdivision 1. Total Appropriation** **\$ (342,045,000)**

514.17 **Appropriations by Fund**

514.18 **2017**

514.19 **General Fund** **(198,450,000)**

514.20 **Health Care Access** **(146,590,000)**

514.21 **TANF** **2,995,000**

514.22 **Subd. 2. Forecasted Programs**

514.23 **(a) MFIP/DWP Grants**

514.24 **Appropriations by Fund**

514.25 **General Fund** **(2,111,000)**

514.26 **TANF** **2,579,000**

514.27 **(b) MFIP Child Care Assistance Grants** **(6,513,000)**

514.28 **(c) General Assistance Grants** **(4,219,000)**

514.29 **(d) Minnesota Supplemental Aid Grants** **(581,000)**

514.30 **(e) Group Residential Housing Grants** **(533,000)**

514.31 **(f) Northstar Care for Children** **2,613,000**

514.32 **(g) MinnesotaCare Grants** **(145,883,000)**

515.1 This appropriation is from the health care
 515.2 access fund.

515.3 **(h) Medical Assistance Grants**

515.4 Appropriations by Fund

515.5 General Fund (192,744,000)

515.6 Health Care Access (707,000)

515.7 **(i) Alternative Care Grants** -0-

515.8 **(j) CD Entitlement Grants** 5,638,000

515.9 Subd. 3. Technical Activities 416,000

515.10 This appropriation is from the TANF fund.

515.11 **Sec. 3. EFFECTIVE DATE.**

515.12 Sections 1 and 2 are effective the day following final enactment.

515.13 **ARTICLE 16**

515.14 **APPROPRIATIONS**

515.15 **Section 1. HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

515.16 The sums shown in the columns marked "Appropriations" are appropriated to the agencies
 515.17 and for the purposes specified in this article. The appropriations are from the general fund,
 515.18 or another named fund, and are available for the fiscal years indicated for each purpose.

515.19 The figures "2018" and "2019" used in this article mean that the appropriations listed under
 515.20 them are available for the fiscal year ending June 30, 2018, or June 30, 2019, respectively.

515.21 "The first year" is fiscal year 2018. "The second year" is fiscal year 2019. "The biennium"
 515.22 is fiscal years 2018 and 2019.

515.23 **APPROPRIATIONS**

515.24 **Available for the Year**

515.25 **Ending June 30**

515.26 **2018** **2019**

515.27 **Sec. 2. COMMISSIONER OF HUMAN**
 515.28 **SERVICES**

515.29 Subdivision 1. Total Appropriation \$ 7,360,594,000 \$ 7,396,706,000

516.1	<u>Appropriations by Fund</u>	
516.2	<u>2018</u>	<u>2019</u>
516.3	<u>General</u>	<u>6,810,781,000</u> <u>6,837,640,000</u>
516.4	<u>State Government</u>	
516.5	<u>Special Revenue</u>	<u>4,274,000</u> <u>4,274,000</u>
516.6	<u>Health Care Access</u>	<u>266,707,000</u> <u>282,194,000</u>
516.7	<u>Federal TANF</u>	<u>276,936,000</u> <u>270,702,000</u>
516.8	<u>Lottery Prize</u>	<u>1,896,000</u> <u>1,896,000</u>

516.9 The amounts that may be spent for each
 516.10 purpose are specified in the following
 516.11 subdivisions.

516.12 **Subd. 2. TANF Maintenance of Effort**

516.13 (a) The commissioner shall ensure that
 516.14 sufficient qualified nonfederal expenditures
 516.15 are made each year to meet the state's
 516.16 maintenance of effort (MOE) requirements of
 516.17 the TANF block grant specified under Code
 516.18 of Federal Regulations, title 45, section 263.1.
 516.19 In order to meet these basic TANF/MOE
 516.20 requirements, the commissioner may report
 516.21 as TANF/MOE expenditures only nonfederal
 516.22 money expended for allowable activities listed
 516.23 in the following clauses:

516.24 (1) MFIP cash, diversionary work program,
 516.25 and food assistance benefits under Minnesota
 516.26 Statutes, chapter 256J;

516.27 (2) the child care assistance programs under
 516.28 Minnesota Statutes, sections 119B.03 and
 516.29 119B.05, and county child care administrative
 516.30 costs under Minnesota Statutes, section
 516.31 119B.15;

516.32 (3) state and county MFIP administrative costs
 516.33 under Minnesota Statutes, chapters 256J and
 516.34 256K;

- 517.1 (4) state, county, and tribal MFIP employment
517.2 services under Minnesota Statutes, chapters
517.3 256J and 256K;
- 517.4 (5) expenditures made on behalf of legal
517.5 noncitizen MFIP recipients who qualify for
517.6 the MinnesotaCare program under Minnesota
517.7 Statutes, chapter 256L;
- 517.8 (6) qualifying working family credit
517.9 expenditures under Minnesota Statutes, section
517.10 290.0671;
- 517.11 (7) qualifying Minnesota education credit
517.12 expenditures under Minnesota Statutes, section
517.13 290.0674; and
- 517.14 (8) qualifying Head Start expenditures under
517.15 Minnesota Statutes, section 119A.50.
- 517.16 (b) For the activities listed in paragraph (a),
517.17 clauses (2) to (8), the commissioner may
517.18 report only expenditures that are excluded
517.19 from the definition of assistance under Code
517.20 of Federal Regulations, title 45, section
517.21 260.31.
- 517.22 (c) The commissioner shall ensure that the
517.23 MOE used by the commissioner of
517.24 management and budget for the February and
517.25 November forecasts required under Minnesota
517.26 Statutes, section 16A.103, contains
517.27 expenditures under paragraph (a), clause (1),
517.28 equal to at least 16 percent of the total required
517.29 under Code of Federal Regulations, title 45,
517.30 section 263.1.
- 517.31 (d) The commissioner may not claim an
517.32 amount of TANF/MOE in excess of the 75
517.33 percent standard in Code of Federal

518.1 Regulations, title 45, section 263.1(a)(2),
518.2 except:

518.3 (1) to the extent necessary to meet the 80
518.4 percent standard under Code of Federal
518.5 Regulations, title 45, section 263.1(a)(1), if it
518.6 is determined by the commissioner that the
518.7 state will not meet the TANF work
518.8 participation target rate for the current year;

518.9 (2) to provide any additional amounts under
518.10 Code of Federal Regulations, title 45, section
518.11 264.5, that relate to replacement of TANF
518.12 funds due to the operation of TANF penalties;
518.13 and

518.14 (3) to provide any additional amounts that may
518.15 contribute to avoiding or reducing TANF work
518.16 participation penalties through the operation
518.17 of the excess MOE provisions of Code of
518.18 Federal Regulations, title 45, section 261.43
518.19 (a)(2).

518.20 (e) For the purposes of paragraph (d), the
518.21 commissioner may supplement the MOE claim
518.22 with working family credit expenditures or
518.23 other qualified expenditures to the extent such
518.24 expenditures are otherwise available after
518.25 considering the expenditures allowed in this
518.26 subdivision.

518.27 (f) The requirement in Minnesota Statutes,
518.28 section 256.011, subdivision 3, that federal
518.29 grants or aids secured or obtained under that
518.30 subdivision be used to reduce any direct
518.31 appropriations provided by law, does not apply
518.32 if the grants or aids are federal TANF funds.

518.33 (g) **IT Appropriations Generally.** This
518.34 appropriation includes funds for information

519.1 technology projects, services, and support.

519.2 Notwithstanding Minnesota Statutes, section

519.3 16E.0466, funding for information technology

519.4 project costs shall be incorporated into the

519.5 service level agreement and paid to the Office

519.6 of MN.IT Services by the Department of

519.7 Human Services under the rates and

519.8 mechanism specified in that agreement.

519.9 **(h) Receipts for Systems Project.**

519.10 Appropriations and federal receipts for

519.11 information systems projects for MAXIS,

519.12 PRISM, MMIS, ISDS, METS, and SSIS must

519.13 be deposited in the state systems account

519.14 authorized in Minnesota Statutes, section

519.15 256.014. Money appropriated for computer

519.16 projects approved by the commissioner of the

519.17 Office of MN.IT Services, funded by the

519.18 legislature, and approved by the commissioner

519.19 of management and budget may be transferred

519.20 from one project to another and from

519.21 development to operations as the

519.22 commissioner of human services considers

519.23 necessary. Any unexpended balance in the

519.24 appropriation for these projects does not

519.25 cancel and is available for ongoing

519.26 development and operations.

519.27 **(i) Federal SNAP Education and Training**

519.28 **Grants.** Federal funds available during fiscal

519.29 years 2017, 2018, and 2019 for Supplemental

519.30 Nutrition Assistance Program Education and

519.31 Training and SNAP Quality Control

519.32 Performance Bonus grants are appropriated

519.33 to the commissioner of human services for the

519.34 purposes allowable under the terms of the

520.1 federal award. This paragraph is effective the
 520.2 day following final enactment.

520.3 **Subd. 3. Central Office; Operations**

520.4 Appropriations by Fund

520.5	<u>General</u>	<u>102,300,000</u>	<u>100,237,000</u>
520.6	<u>State Government</u>		
520.7	<u>Special Revenue</u>	<u>4,149,000</u>	<u>4,149,000</u>
520.8	<u>Health Care Access</u>	<u>20,025,000</u>	<u>20,025,000</u>
520.9	<u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>

520.10 **(a) Administrative Recovery; Set-Aside.** The
 520.11 commissioner may invoice local entities
 520.12 through the SWIFT accounting system as an
 520.13 alternative means to recover the actual cost of
 520.14 administering the following provisions:

520.15 (1) Minnesota Statutes, section 125A.744,
 520.16 subdivision 3;

520.17 (2) Minnesota Statutes, section 245.495,
 520.18 paragraph (b);

520.19 (3) Minnesota Statutes, section 256B.0625,
 520.20 subdivision 20, paragraph (k);

520.21 (4) Minnesota Statutes, section 256B.0924,
 520.22 subdivision 6, paragraph (g);

520.23 (5) Minnesota Statutes, section 256B.0945,
 520.24 subdivision 4, paragraph (d); and

520.25 (6) Minnesota Statutes, section 256F.10,
 520.26 subdivision 6, paragraph (b).

520.27 **(b) Transfer to Office of Legislative**

520.28 **Auditor.** \$600,000 in fiscal year 2018 and
 520.29 \$600,000 in fiscal year 2019 are for transfer
 520.30 to the Office of the Legislative Auditor for
 520.31 audit activities under Minnesota Statutes,
 520.32 section 3.972, subdivision 2b.

521.1 (c) Base Level Adjustment. The general fund
 521.2 base is \$98,094,000 in fiscal year 2020 and
 521.3 \$98,085,000 in fiscal year 2021.

521.4 Subd. 4. Central Office; Children and Families

	<u>Appropriations by Fund</u>	
521.5		
521.6	<u>General</u>	<u>9,043,000</u> <u>8,931,000</u>
521.7	<u>Federal TANF</u>	<u>2,582,000</u> <u>2,582,000</u>

521.8 (a) Financial Institution Data Match and
 521.9 Payment of Fees. The commissioner is
 521.10 authorized to allocate up to \$310,000 each
 521.11 year in fiscal year 2018 and fiscal year 2019
 521.12 from the systems special revenue account to
 521.13 make payments to financial institutions in
 521.14 exchange for performing data matches
 521.15 between account information held by financial
 521.16 institutions and the public authority's database
 521.17 of child support obligors as authorized by
 521.18 Minnesota Statutes, section 13B.06,
 521.19 subdivision 7.

521.20 (b) Base Level Adjustment. The general fund
 521.21 base is \$8,871,000 in fiscal year 2020 and
 521.22 \$8,871,000 in fiscal year 2021.

521.23 Subd. 5. Central Office; Health Care

	<u>Appropriations by Fund</u>	
521.24		
521.25	<u>General</u>	<u>17,877,000</u> <u>16,963,000</u>
521.26	<u>Health Care Access</u>	<u>21,641,000</u> <u>21,748,000</u>

521.27 (a) Trust Guide. \$200,000 in fiscal year 2018
 521.28 and \$150,000 in fiscal year 2019 are from the
 521.29 general fund for the development of a special
 521.30 needs trust guide that directs the state medical
 521.31 assistance program's trust recovery process
 521.32 and establishes guidelines for the public. This
 521.33 is a onetime appropriation.

- 522.1 (b) Rates Study. \$227,000 in fiscal year 2018
522.2 is from the general fund for the medical
522.3 assistance payment rate study. This is a
522.4 onetime appropriation.
- 522.5 (c) Integrated Health Partnership Health
522.6 Information Exchange. \$125,000 in fiscal
522.7 year 2018 and \$250,000 in fiscal year 2019
522.8 are from the general fund to contract with
522.9 state-certified health information exchange
522.10 vendors to support providers participating in
522.11 an integrated health partnership under
522.12 Minnesota Statutes, section 256B.0755, to
522.13 connect enrollees with community supports
522.14 and social services and improve collaboration
522.15 among participating and authorized providers.
- 522.16 (d) Implementation and Operation of an
522.17 Electronic Service Delivery Documentation
522.18 System. \$225,000 in fiscal year 2018 and
522.19 \$183,000 in fiscal year 2019 are from the
522.20 general fund for the development and
522.21 implementation of an electronic service
522.22 delivery documentation system. This is a
522.23 onetime appropriation.
- 522.24 (e) Transfer to Legislative Auditor.
522.25 \$153,000 in fiscal year 2018 and \$153,000 in
522.26 fiscal year 2019 are from the general fund for
522.27 transfer to the Office of the Legislative
522.28 Auditor for the auditor to establish and
522.29 maintain a team of auditors with the training
522.30 and experience necessary to fulfill the
522.31 requirements in Minnesota Statutes, section
522.32 3.972, subdivision 2a.
- 522.33 (f) Savings from Improved Eligibility
522.34 Verification. The commissioner of human
522.35 services shall implement periodic data

523.1 matching under Minnesota Statutes, section
 523.2 256B.0561, the recommendations of the
 523.3 legislative auditor provided under Minnesota
 523.4 Statutes, section 3.972, subdivision 2a, and
 523.5 other eligibility verification initiatives for
 523.6 enrollees or beneficiaries of all health care,
 523.7 income maintenance, and social service
 523.8 programs administered by the commissioner,
 523.9 in a manner sufficient to achieve savings of
 523.10 \$65,548,000 in fiscal year 2018 and
 523.11 \$74,689,000 in fiscal year 2019.

523.12 **(g) Chronic Pain Rehabilitation Therapy**
 523.13 **Demonstration Project. \$1,000,000 in fiscal**
 523.14 **year 2018 is from the general fund for a**
 523.15 **chronic pain rehabilitation therapy**
 523.16 **demonstration project with a rehabilitation**
 523.17 **institute. This is a onetime appropriation.**

523.18 **(h) Base Level Adjustment. The general fund**
 523.19 **base is \$16,221,000 in fiscal year 2020 and**
 523.20 **\$16,219,000 in fiscal year 2021.**

523.21 **Subd. 6. Central Office; Continuing Care for**
 523.22 **Older Adults**

523.23	<u>Appropriations by Fund</u>	
523.24	<u>General</u>	<u>14,565,000</u> <u>14,061,000</u>
523.25	<u>State Government</u>	
523.26	<u>Special Revenue</u>	<u>125,000</u> <u>125,000</u>

523.27 **(a) Vulnerable Adults Complaints Case**
 523.28 **Management System. \$258,000 in fiscal year**
 523.29 **2018 is from the general fund for the Office**
 523.30 **of Inspector General to implement a case**
 523.31 **management system for tracking and**
 523.32 **managing complaints and investigations**
 523.33 **involving vulnerable adults. In consultation**
 523.34 **with the Department of Health, Office of**
 523.35 **Health Facility Complaints, the Office of**

524.1 Inspector General shall ensure that the case
524.2 management system is capable of:

524.3 (1) uniquely tracking each complaint received
524.4 by the Office of Inspector General and the
524.5 Office of Health Facility Complaints, whether
524.6 the complaint is received through the
524.7 Minnesota Adult Abuse Reporting Center, by
524.8 telephone, by referral from another agency or
524.9 division, or by any other means;

524.10 (2) linking each complaint to any and all
524.11 investigations related to that complaint;

524.12 (3) tracking and coordinating referrals and
524.13 communication between state agencies,
524.14 including the Office of Ombudsman for
524.15 Long-Term Care and the Office of
524.16 Ombudsman for Mental Health and
524.17 Developmental Disabilities; and

524.18 (4) securing data as required under the
524.19 Vulnerable Adults Act and the Government
524.20 Data Practices Act.

524.21 Products and services for the case management
524.22 system design, implementation, and
524.23 application hosting must be acquired using a
524.24 request for proposals. This is a onetime
524.25 appropriation and is available until June 30,
524.26 2019.

524.27 **(b) Alzheimer's Disease Working Group.**
524.28 \$127,000 in fiscal year 2018 and \$110,000 in
524.29 fiscal year 2019 are from the general fund for
524.30 the Alzheimer's disease working group. This
524.31 is a onetime appropriation.

524.32 **(c) Base Level Adjustment.** The general fund
524.33 base is \$13,909,000 in fiscal year 2020 and
524.34 \$13,909,000 in fiscal year 2021.

525.1 Subd. 7. Central Office; Community Supports525.2 Appropriations by Fund525.3 General 26,358,000 26,021,000525.4 Lottery Prize 163,000 163,000525.5 (a) Transportation Study. \$250,000 in fiscal525.6 year 2018 and \$250,000 in fiscal year 2019525.7 are for a study to identify opportunities to525.8 increase access to transportation services for525.9 individuals who receive home and525.10 community-based services. This is a onetime525.11 appropriation.525.12 (b) Deaf and Hard-of-Hearing Services.525.13 \$850,000 in fiscal year 2018 and \$700,000 in525.14 fiscal year 2019 are from the general fund for525.15 the Deaf and Hard-of-Hearing Services525.16 Division under Minnesota Statutes, section525.17 256C.233. \$150,000 of this appropriation each525.18 year must be used for technology525.19 improvements, technology support, and525.20 training for staff on the use of technology for525.21 external facing services to implement525.22 Minnesota Statutes, section 256C.24,525.23 subdivision 2, clause (12).525.24 (c) Individual Budgeting Model. \$435,000525.25 in fiscal year 2018 and \$65,000 in fiscal year525.26 2019 are from the general fund to study and525.27 develop an individual budgeting model for525.28 disability waiver recipients and those525.29 accessing services through consumer-directed525.30 community supports. The commissioner shall525.31 submit recommendations to the chairs and525.32 ranking minority members of the legislative525.33 committees with jurisdiction over these525.34 programs by January 15, 2019. This is a525.35 onetime appropriation.

526.1 **(d) Substance Use Disorder System Study.**
 526.2 \$150,000 in fiscal year 2018 and \$150,000 in
 526.3 fiscal year 2019 are for a substance use
 526.4 disorder system study. This is a onetime
 526.5 appropriation.

526.6 **(e) Children's Mental Health Report and**
 526.7 **Recommendations.** \$125,000 in fiscal year
 526.8 2018 and \$125,000 in fiscal year 2019 are for
 526.9 a comprehensive analysis of Minnesota's
 526.10 continuum of intensive mental health services
 526.11 for children with serious mental health needs.
 526.12 This is a onetime appropriation.

526.13 **(f) Base Level Adjustment.** The general fund
 526.14 base is \$24,650,000 in fiscal year 2020 and
 526.15 \$24,533,000 in fiscal year 2021.

526.16 **Subd. 8. Forecasted Programs; MFIP/DWP**

526.17	<u>Appropriations by Fund</u>	
526.18	<u>General</u>	<u>88,530,000</u> <u>97,912,000</u>
526.19	<u>Federal TANF</u>	<u>94,617,000</u> <u>88,230,000</u>

526.20 **Subd. 9. Forecasted Programs; MFIP Child Care**
 526.21 **Assistance**

	<u>107,385,000</u>	<u>103,796,000</u>
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526.22 **Subd. 10. Forecasted Programs; General**
 526.23 **Assistance**

	<u>55,536,000</u>	<u>57,221,000</u>
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526.24 **(a) General Assistance Standard.** The
 526.25 commissioner shall set the monthly standard
 526.26 of assistance for general assistance units
 526.27 consisting of an adult recipient who is
 526.28 childless and unmarried or living apart from
 526.29 parents or a legal guardian at \$203. The
 526.30 commissioner may reduce this amount
 526.31 according to Laws 1997, chapter 85, article 3,
 526.32 section 54.

526.33 **(b) Emergency General Assistance Limit.**

526.34 The amount appropriated for emergency
 526.35 general assistance is limited to no more than

527.1 \$6,729,812 in fiscal year 2018 and \$6,729,812
 527.2 in fiscal year 2019. Funds to counties shall be
 527.3 allocated by the commissioner using the
 527.4 allocation method under Minnesota Statutes,
 527.5 section 256D.06.

527.6 **Subd. 11. Forecasted Programs; Minnesota**
 527.7 **Supplemental Aid**

40,484,000

41,634,000

527.8 **Subd. 12. Forecasted Programs; Group**
 527.9 **Residential Housing**

170,337,000

180,668,000

527.10 **Subd. 13. Forecasted Programs; Northstar Care**
 527.11 **for Children**

80,542,000

96,433,000

527.12 **Subd. 14. Forecasted Programs; MinnesotaCare**

12,224,000

12,834,000

527.13 This appropriation is from the health care
 527.14 access fund.

527.15 **Subd. 15. Forecasted Programs; Medical**
 527.16 **Assistance**

527.17 Appropriations by Fund

527.18 General 5,211,349,000 5,192,343,000

527.19 Health Care Access 210,159,000 224,929,000

527.20 **(a) Behavioral Health Services. \$1,000,000**

527.21 in fiscal year 2018 and \$1,000,000 in fiscal

527.22 year 2019 are for behavioral health services

527.23 provided by hospitals identified under

527.24 Minnesota Statutes, section 256.969,

527.25 subdivision 2b, paragraph (a), clause (4). The

527.26 increase in payments shall be made by

527.27 increasing the adjustment under Minnesota

527.28 Statutes, section 256.969, subdivision 2b,

527.29 paragraph (e), clause (2).

527.30 **(b) Limits to Increases in Medical**

527.31 **Assistance Program Payments. Beginning**

527.32 **July 1, 2017, the commissioner shall limit**

527.33 **increases in payments to managed care plans**

527.34 **and county-based purchasing plans in the**

527.35 **medical assistance program to achieve the**

528.1 following reductions on a statewide aggregate

528.2 basis for each fiscal year:

528.3 (1) in fiscal year 2018, \$32,682,000;

528.4 (2) in fiscal year 2019, \$118,257,000;

528.5 (3) in fiscal year 2020, \$218,025,000; and

528.6 (4) in fiscal year 2021, \$327,396,000.

528.7 Notwithstanding any provision to the contrary

528.8 in this article, this paragraph expires July 1,

528.9 2021.

528.10 **(c) Reform of MnCHOICES**

528.11 **Administration.**The commissioner shall

528.12 reduce expenditures for MnCHOICES by

528.13 \$30,753,000 in fiscal year 2018 and

528.14 \$30,753,000 in fiscal year 2019.

528.15 **Subd. 16. Forecasted Programs; Alternative**

528.16 **Care**

44,587,000

45,477,000

528.17 **Alternative Care Transfer.** Any money

528.18 allocated to the alternative care program that

528.19 is not spent for the purposes indicated does

528.20 not cancel but must be transferred to the

528.21 medical assistance account.

528.22 **Subd. 17. Forecasted Programs; Chemical**

528.23 **Dependency Treatment Fund**

119,251,000

139,321,000

528.24 **Subd. 18. Grant Programs; Support Services**

528.25 **Grants**

528.26 Appropriations by Fund

528.27 General 8,715,000 8,715,000

528.28 Federal TANF 93,311,000 93,311,000

528.29 **Subd. 19. Grant Programs; Basic Sliding Fee**

528.30 **Child Care Assistance Grants**

51,945,000

48,660,000

528.31 **Base Level Adjustment.** The general fund

528.32 base is \$48,737,000 in fiscal year 2020 and

528.33 \$48,809,000 in fiscal year 2021.

529.1	<u>Subd. 20. Grant Programs; Child Care</u>		
529.2	<u>Development Grants</u>		<u>1,737,000</u>
			<u>1,737,000</u>
529.3	<u>Subd. 21. Grant Programs; Child Support</u>		
529.4	<u>Enforcement Grants</u>		<u>50,000</u>
			<u>50,000</u>
529.5	<u>Subd. 22. Grant Programs; Children's Services</u>		
529.6	<u>Grants</u>		
529.7	<u>Appropriations by Fund</u>		
529.8	<u>General</u>	<u>41,140,000</u>	<u>40,265,000</u>
529.9	<u>Federal TANF</u>	<u>140,000</u>	<u>140,000</u>
529.10	<u>(a) Title IV-E Adoption Assistance. (1) The</u>		
529.11	<u>commissioner shall allocate funds from the</u>		
529.12	<u>Title IV-E reimbursement to the state from</u>		
529.13	<u>the Fostering Connections to Success and</u>		
529.14	<u>Increasing Adoptions Act for adoptive, foster,</u>		
529.15	<u>and kinship families as required in Minnesota</u>		
529.16	<u>Statutes, section 256N.621.</u>		
529.17	<u>(2) Additional federal reimbursement to the</u>		
529.18	<u>state as a result of the Fostering Connections</u>		
529.19	<u>to Success and Increasing Adoptions Act's</u>		
529.20	<u>expanded eligibility for title IV-E adoption</u>		
529.21	<u>assistance is for postadoption, foster care,</u>		
529.22	<u>adoption, and kinship services, including a</u>		
529.23	<u>parent-to-parent support network.</u>		
529.24	<u>(b) Adoption Assistance Incentive Grants.</u>		
529.25	<u>(1) The commissioner shall allocate federal</u>		
529.26	<u>funds available for adoption and guardianship</u>		
529.27	<u>assistance incentive grants for postadoption</u>		
529.28	<u>services to support adoptive, foster, and</u>		
529.29	<u>kinship families as required in Minnesota</u>		
529.30	<u>Statutes, section 256N.621.</u>		
529.31	<u>(2) Federal funds available during fiscal years</u>		
529.32	<u>2018 and 2019 for adoption incentive grants</u>		
529.33	<u>must be used for foster care, adoption, and</u>		
529.34	<u>kinship services, including a parent-to-parent</u>		
529.35	<u>support network.</u>		

530.1 (c) Adoption Support Services. The
 530.2 commissioner shall allocate 20 percent of
 530.3 federal funds from title IV-B, subpart 2, of the
 530.4 Social Security Act, Promoting Safe and
 530.5 Stable Families, for adoption support services
 530.6 under Minnesota Statutes, section 256N.261.

530.7 (d) American Indian Child Welfare
 530.8 Initiative. \$800,000 in fiscal year 2018 is for
 530.9 planning efforts to expand the American
 530.10 Indian Child Welfare Initiative under
 530.11 Minnesota Statutes, section 256.01,
 530.12 subdivision 14b. Of this amount, \$400,000 is
 530.13 for a grant to the Mille Lacs Band of Ojibwe
 530.14 and \$400,000 is for a grant to the Red Lake
 530.15 Nation. This is a onetime appropriation.

530.16 (e) Anoka County Family Foster Care.
 530.17 \$75,000 in fiscal year 2018 is from the general
 530.18 fund for a grant to Anoka County to establish
 530.19 and promote family foster care recruitment
 530.20 models. The county shall use the grant funds
 530.21 for the purpose of increasing foster care
 530.22 providers through administrative
 530.23 simplification, nontraditional recruitment
 530.24 models, and family incentive options, and
 530.25 develop a strategic planning model to recruit
 530.26 family foster care providers. This is a onetime
 530.27 appropriation.

530.28 (f) White Earth Band of Ojibwe Child
 530.29 Welfare Services. \$1,600,000 in fiscal year
 530.30 2018 and \$1,600,000 in fiscal year 2019 are
 530.31 from the general fund for a grant to the White
 530.32 Earth Band of Ojibwe to deliver child welfare
 530.33 services.

530.34 Subd. 23. Grant Programs; Children and
 530.35 Community Service Grants

58,201,000

58,201,000

531.1	<u>Subd. 24. Grant Programs; Children and</u>		
531.2	<u>Economic Support Grants</u>	<u>35,851,000</u>	<u>32,891,000</u>
531.3	<u>(a) Minnesota Food Assistance Program.</u>		
531.4	<u>Unexpended funds for the Minnesota food</u>		
531.5	<u>assistance program for fiscal year 2018 do not</u>		
531.6	<u>cancel but are available for this purpose in</u>		
531.7	<u>fiscal year 2019.</u>		
531.8	<u>(b) At-Home Infant Child Care. \$961,000</u>		
531.9	<u>in fiscal year 2018 and \$961,000 in fiscal year</u>		
531.10	<u>2019 are from the general fund for the at-home</u>		
531.11	<u>infant child care program under Minnesota</u>		
531.12	<u>Statutes, section 119B.035. The base for these</u>		
531.13	<u>grants is \$922,000 in fiscal year 2020 and</u>		
531.14	<u>\$922,000 in fiscal year 2021.</u>		
531.15	<u>(c) Long-term Homeless Supportive</u>		
531.16	<u>Services. \$500,000 in fiscal year 2018 and</u>		
531.17	<u>\$500,000 in fiscal year 2019 are for the</u>		
531.18	<u>long-term homeless supportive services fund</u>		
531.19	<u>under Minnesota Statutes, section 256K.26.</u>		
531.20	<u>This is a onetime appropriation.</u>		
531.21	<u>(d) Community Action Grants. \$750,000 in</u>		
531.22	<u>fiscal year 2018 and \$750,000 in fiscal year</u>		
531.23	<u>2019 are for community action grants under</u>		
531.24	<u>Minnesota Statutes, sections 256E.30 to</u>		
531.25	<u>256E.32.</u>		
531.26	<u>(e) Transitional Housing. \$250,000 in fiscal</u>		
531.27	<u>year 2018 and \$250,000 in fiscal year 2019</u>		
531.28	<u>are for the transitional housing program under</u>		
531.29	<u>Minnesota Statutes, section 256E.33. This is</u>		
531.30	<u>a onetime appropriation.</u>		
531.31	<u>(f) Family Assets for Independence.</u>		
531.32	<u>\$250,000 in fiscal year 2018 and \$250,000 in</u>		
531.33	<u>fiscal year 2019 are for the family assets for</u>		

532.1 independence program under Minnesota
532.2 Statutes, section 256E.35.

532.3 **(g) Safe Harbor for Sexually Exploited**
532.4 **Youth.** (1) \$500,000 in fiscal year 2018 and
532.5 \$500,000 in fiscal year 2019 are for
532.6 emergency shelter and transitional and
532.7 long-term housing beds for sexually exploited
532.8 youth and youth at risk of sexual exploitation.

532.9 (2) \$100,000 in fiscal year 2018 and \$100,000
532.10 in fiscal year 2019 are for statewide youth
532.11 outreach workers connecting sexually
532.12 exploited youth and youth at risk of sexual
532.13 exploitation with shelter and services.

532.14 (3) Youth 24 years of age or younger are
532.15 eligible for shelter, housing beds, and services
532.16 under this paragraph. In funding shelter,
532.17 housing beds, and outreach workers under this
532.18 paragraph, the commissioner shall emphasize
532.19 activities that promote capacity-building and
532.20 development of resources in greater
532.21 Minnesota.

532.22 **(h) Emergency Services Program.** \$125,000
532.23 in fiscal year 2018 and \$125,000 in fiscal year
532.24 2019 are for the emergency services program,
532.25 which provides services and emergency shelter
532.26 for homeless Minnesotans under Minnesota
532.27 Statutes, section 256E.36. This is a onetime
532.28 appropriation.

532.29 **(i) Dakota County Child Data Tracking.**
532.30 \$200,000 in fiscal year 2018 is for the
532.31 Minnesota Birth to Eight pilot project for the
532.32 development of the information technology
532.33 solution that will track the established

533.1 developmental milestone progress of each
533.2 child participating in the pilot up to age eight.

533.3 **(j) Mobile Food Shelf Grants.** \$2,000,000 in
533.4 fiscal year 2018 is for mobile food shelf
533.5 grants. Of this amount, \$1,000,000 is for
533.6 sustaining existing mobile programs and
533.7 \$1,000,000 is for creating new mobile
533.8 programs. This is a onetime appropriation.

533.9 **(k) Food Shelf Programs.** \$565,000 in fiscal
533.10 year 2018 and \$565,000 in fiscal year 2019
533.11 are for food shelf programs under Minnesota
533.12 Statutes, section 256E.34. This appropriation
533.13 may be used to purchase proteins, fruits,
533.14 vegetables, and diapers.

533.15 **(l) Housing Benefit Web Site.** \$130,000 in
533.16 fiscal year 2018 and \$130,000 in fiscal year
533.17 2019 are to operate the housing benefit 101
533.18 Web site to help people who need affordable
533.19 housing, and supports to maintain that
533.20 housing, understand the range of housing
533.21 options and support services available.

533.22 **(m) Coparenting Education.** \$200,000 in
533.23 fiscal year 2018 and \$200,000 in fiscal year
533.24 2019 are for a grant to a health and wellness
533.25 center located in North Minneapolis that is a
533.26 federally qualified health center. This is a
533.27 onetime appropriation. The center must use
533.28 the grant money to offer coparent services to
533.29 unmarried parents. The center must develop
533.30 a process to inform and educate unmarried
533.31 parents about the center's coparent services.
533.32 The coparent services must include the
533.33 following:

- 534.1 (1) coparenting workshops for the unmarried
534.2 parents;
- 534.3 (2) assistance to the unmarried parents in
534.4 developing a parenting plan that specifies a
534.5 schedule of the time each parent spends with
534.6 the child, child support obligations, and a
534.7 designation of decision-making responsibilities
534.8 regarding the child's education, medical needs,
534.9 and religious upbringing;
- 534.10 (3) an assessment of social services needs for
534.11 each parent; and
- 534.12 (4) additional social services support,
534.13 including support related to employment,
534.14 education, and housing.
- 534.15 The parenting plan assistance must include
534.16 the option of using private mediation.
- 534.17 The coparent workshops must focus at a
534.18 minimum on (i) the benefits to the child of
534.19 having both parents involved in a child's life,
534.20 (ii) promoting both parents' participation in a
534.21 child's life, (iii) building coparenting and
534.22 communication skills, (iv) information on
534.23 establishing paternity, (v) assisting parents in
534.24 developing a parenting plan, and (vi) educating
534.25 participants on how to foster a nonresident
534.26 parent's continued involvement in a child's
534.27 life.
- 534.28 **(n) Safe Harbor Shelter and Housing**
534.29 **Project.** \$970,000 in fiscal year 2018 is for a
534.30 grant to a girls' ranch in Benson that provides
534.31 housing, supportive services, educational
534.32 services, and equine therapy, for purposes of
534.33 predesigning, designing, constructing,
534.34 furnishing, and equipping a house with

535.1 capacity for ten beds, and a second horse
 535.2 riding arena. This is a onetime appropriation.

535.3 **(o) Base Level Adjustments.** The general
 535.4 fund base is \$32,230,000 in fiscal year 2020
 535.5 and \$32,230,000 in fiscal year 2021. The
 535.6 general fund base includes \$453,000 in fiscal
 535.7 year 2020 and \$453,000 in fiscal year 2021
 535.8 for community living infrastructure grant
 535.9 allocations under Minnesota Statutes, section
 535.10 256I.09.

535.11 **Subd. 25. Grant Programs; Health Care Grants**

535.12	<u>Appropriations by Fund</u>		
535.13	<u>General</u>	<u>4,994,000</u>	<u>4,461,000</u>
535.14	<u>Health Care Access</u>	<u>1,908,000</u>	<u>1,908,000</u>

535.15 **(a) Integrated Health Partnerships.**
 535.16 \$375,000 in fiscal year 2018 and \$250,000 in
 535.17 fiscal year 2019 are from the general fund to
 535.18 provide financial assistance to participating
 535.19 providers for costs required to establish an
 535.20 integrated health partnership, including but
 535.21 not limited to collecting and reporting
 535.22 information on health outcomes, quality of
 535.23 care, and health care costs; training
 535.24 practitioners and staff to use new care models
 535.25 and participate in care coordination; or
 535.26 participating in research and evaluation of the
 535.27 projects. This is a onetime appropriation.

535.28 **(b) Dental Services Grants.** \$500,000 in
 535.29 fiscal year 2018 and \$500,000 in fiscal year
 535.30 2019 are to award dental services grants. This
 535.31 is a onetime appropriation. The commissioner
 535.32 may award grants under this paragraph to:

535.33 (1) nonprofit community clinics;

536.1 (2) federally qualified health centers, rural
 536.2 health clinics, and public health clinics;
 536.3 (3) hospital-based dental clinics owned and
 536.4 operated by a city, county, or former state
 536.5 hospital as defined in Minnesota Statutes,
 536.6 section 62Q.19, subdivision 1, paragraph (a),
 536.7 clause (4); and

536.8 (4) a dental clinic owned and operated by the
 536.9 University of Minnesota or the Minnesota
 536.10 State Colleges and Universities system.

536.11 Grants may be used to fund costs related to
 536.12 maintaining, coordinating, and improving
 536.13 access for medical assistance and
 536.14 MinnesotaCare enrollees to dental care in a
 536.15 region.

536.16 The commissioner shall consider the following
 536.17 in awarding the grants: experience in
 536.18 delivering dental services to medical assistance
 536.19 and MinnesotaCare enrollees in urban and
 536.20 rural communities; the potential to
 536.21 successfully maintain or expand access to
 536.22 dental services for medical assistance and
 536.23 MinnesotaCare enrollees; and demonstrated
 536.24 capability to provide access to care for
 536.25 children, adults, and seniors with special
 536.26 needs, individuals with complex medical and
 536.27 dental needs, recent immigrants and
 536.28 non-English speakers, and students attending
 536.29 schools with a high percentage of low-income
 536.30 students.

536.31 (c) **Base Level Adjustment.** The general fund
 536.32 base is \$3,711,000 in fiscal year 2020 and
 536.33 \$3,711,000 in fiscal year 2021.

536.34 Subd. 26. **Grant Programs; Other Long-Term**
 536.35 **Care Grants**

3,053,000

3,478,000

537.1 (a) Home and Community-Based Incentive537.2 Pool. \$1,553,000 in fiscal year 2018 and537.3 \$1,553,000 in fiscal year 2019 are for537.4 incentive payments under Minnesota Statutes,537.5 section 256B.0921. The base for these grants537.6 is \$1,059,000 in fiscal year 2020 and537.7 \$1,059,000 in fiscal year 2021.537.8 (b) Base Level Adjustment. The general fund537.9 base is \$2,984,000 in fiscal year 2020 and537.10 \$2,984,000 in fiscal year 2021.537.11 Subd. 27. Grant Programs; Aging and Adult537.12 Services Grants30,986,00032,637,000537.13 (a) Caregiver Support Programs. \$200,000537.14 in fiscal year 2018 and \$200,000 in fiscal year537.15 2019 are for caregiver support programs under537.16 Minnesota Statutes, section 256.9755.537.17 (b) Advanced In-Home Activity-Monitoring537.18 Systems. \$40,000 in fiscal year 2018 is for a537.19 grant to a local research organization with537.20 expertise in identifying current and potential537.21 support systems and examining the capacity537.22 of those systems to meet the needs of the537.23 growing population of elderly persons to537.24 conduct a comprehensive assessment of537.25 current literature, past research, and an537.26 environmental scan of the field related to537.27 advanced in-home activity-monitoring systems537.28 for elderly persons. The commissioner must537.29 report the results of the assessment by January537.30 15, 2018, to the legislative committees and537.31 divisions with jurisdiction over health and537.32 human services policy and finance. This is a537.33 onetime appropriation.537.34 (c) Base Level Adjustments. The general537.35 fund base is \$33,011,000 in fiscal year 2020

538.1 and \$33,195,000 in fiscal year 2021. The
 538.2 general fund base includes \$334,000 in fiscal
 538.3 year 2020 and \$477,000 in fiscal year 2021
 538.4 for the Minnesota Board on Aging for
 538.5 self-directed caregiver grants under Minnesota
 538.6 Statutes, section 256.975, subdivision 12.

538.7 **Subd. 28. Grant Programs; Deaf and**
 538.8 **Hard-of-Hearing Grants**

2,625,000

2,775,000

538.9 **Expanded Services Grants. \$750,000 in**
 538.10 fiscal year 2018 and \$900,000 in fiscal year
 538.11 2019 are for deaf and hard-of-hearing grants.
 538.12 The funds must be used to provide services to
 538.13 Minnesotans who are deafblind under
 538.14 Minnesota Statutes, section 256C.261, to
 538.15 provide culturally affirmative psychiatric
 538.16 services, and to provide linguistically and
 538.17 culturally appropriate mental health services
 538.18 to children who are deaf, children who are
 538.19 deafblind, and children who are
 538.20 hard-of-hearing. Of this amount, \$103,000 in
 538.21 each year is to increase the grant to provide
 538.22 mentors who have hearing loss to parents of
 538.23 infants and children with newly identified
 538.24 hearing loss. Each year the division must
 538.25 provide funds for training in ProTactile
 538.26 American Sign Language or other
 538.27 communication systems used by people who
 538.28 are deafblind. Training shall be provided to
 538.29 persons who are deafblind and to interpreters,
 538.30 support service providers, and intervenors who
 538.31 work with persons who are deafblind.

538.32 **Subd. 29. Grant Programs; Disabilities Grants**

21,300,000

21,301,000

538.33 **(a) Disability Waiver Rate System**

538.34 **Transition Grants. \$30,000 in fiscal year**

538.35 2018 and \$31,000 in fiscal year 2019 are for

539.1 grants to home and community-based
539.2 disability waiver services providers that are
539.3 projected to receive at least a ten percent
539.4 decrease in revenues due to transition to rates
539.5 calculated under Minnesota Statutes, section
539.6 256B.4914. The commissioner shall award
539.7 grants to ensure ongoing access for individuals
539.8 currently receiving these services and provide
539.9 stability to providers as they transition to new
539.10 service delivery models. The general fund base
539.11 for the grants under this paragraph is \$287,000
539.12 in fiscal year 2020 and \$288,000 in fiscal year
539.13 2021.

539.14 **(b) Self-Advocacy Grants.** \$133,000 in fiscal
539.15 year 2018 and \$133,000 in fiscal year 2019
539.16 are for grants under Minnesota Statutes,
539.17 section 256.477, paragraph (a).

539.18 **(c) Services for Persons with Intellectual**
539.19 **and Developmental Disabilities.** \$143,000
539.20 in fiscal year 2018 and \$143,000 in fiscal year
539.21 2019 are for a grant to an organization
539.22 described under Minnesota Statutes, section
539.23 256.477. This is a onetime appropriation.

539.24 Grant funds must be used for the following
539.25 purposes:

539.26 (1) to maintain the infrastructure needed to
539.27 train and support the activities of a statewide
539.28 network of peer-to-peer mentors for persons
539.29 with developmental disabilities, focused on
539.30 building awareness of service options and
539.31 advocacy skills necessary to move toward full
539.32 inclusion in community life, including the
539.33 development and delivery of the curriculum
539.34 to support the peer-to-peer network;

540.1 (2) to provide outreach activities, including
540.2 statewide conferences and disability
540.3 networking opportunities focused on
540.4 self-advocacy, informed choice, and
540.5 community engagement skills;

540.6 (3) to provide an annual leadership program
540.7 for persons with intellectual and
540.8 developmental disabilities; and

540.9 (4) to provide for administrative and general
540.10 operating costs associated with managing and
540.11 maintaining facilities, program delivery,
540.12 evaluation, staff, and technology.

540.13 **(d) Outreach to Persons in Institutional**
540.14 **Settings.** \$105,000 in fiscal year 2018 and
540.15 \$105,000 in fiscal year 2019 are for a grant to
540.16 an organization described under Minnesota
540.17 Statutes, section 256.477, to be used for
540.18 subgrants to organizations in Minnesota to
540.19 conduct outreach to persons working and
540.20 living in institutional settings to provide
540.21 education and information about community
540.22 options. This is a onetime appropriation. Grant
540.23 funds must be used to deliver peer-led skill
540.24 training sessions in six regions of the state to
540.25 help persons with intellectual and
540.26 developmental disabilities understand
540.27 community service options related to:

540.28 (1) housing;

540.29 (2) employment;

540.30 (3) education;

540.31 (4) transportation;

540.32 (5) emerging service reform initiatives
540.33 contained in the state's Olmstead plan; the

541.1 Workforce Innovation and Opportunity Act,
541.2 Public Law 113-128; and federal home and
541.3 community-based services regulations; and
541.4 (6) connecting with individuals who can help
541.5 persons with intellectual and developmental
541.6 disabilities make an informed choice and plan
541.7 for a transition in services.

541.8 **(e) Individual Community Living Grants.**
541.9 To the extent funding is available, the
541.10 commissioner may transfer funds from the
541.11 semi-independent living services grant to new
541.12 individual community living grants to pay for
541.13 transitional costs and facilitate the transition
541.14 of individuals from corporate foster care to
541.15 community living.

541.16 **(f) Gap Analysis.** \$217,000 in fiscal year 2018
541.17 and \$218,000 in fiscal year 2019 are for
541.18 analysis of gaps in long-term care services
541.19 under Minnesota Statutes, section 144A.351.

541.20 **(g) Life Skills Training for Individuals with**
541.21 **Autism Spectrum Disorder.** \$250,000 in
541.22 fiscal year 2018 and \$250,000 in fiscal year
541.23 2019 are for a grant to an organization located
541.24 in Richfield that provides life skills training
541.25 to young adults with learning disabilities to
541.26 meet the needs of individuals with autism
541.27 spectrum disorder. This appropriation may be
541.28 used to:

541.29 (1) create a best practices curriculum for
541.30 servicing individuals with autism spectrum
541.31 disorder in residential placements with
541.32 therapeutic programming; and

541.33 (2) expand facilities by adding safety features,
541.34 living spaces, and academic areas.

542.1 (h) Base Level Adjustment. The general fund
 542.2 base is \$21,309,000 in fiscal year 2020 and
 542.3 \$21,310,000 in fiscal year 2021.

542.4 Subd. 30. Grant Programs; Adult Mental Health
 542.5 Grants

542.6	<u>Appropriations by Fund</u>		
542.7	<u>General</u>	<u>85,402,000</u>	<u>85,302,000</u>
542.8	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>

542.9 (a) Peer-Run Respite Services in Wadena
 542.10 County. \$100,000 in fiscal year 2018 is from
 542.11 the general fund for a grant to Wadena County
 542.12 for the planning and development of a peer-run
 542.13 respite center for individuals experiencing
 542.14 mental health conditions or co-occurring
 542.15 substance abuse disorder. This is a onetime
 542.16 appropriation and is available until June 30,
 542.17 2021. The grant is contingent on Wadena
 542.18 County providing to the commissioner of
 542.19 human services a plan to fund, operate, and
 542.20 sustain the program and services after the
 542.21 onetime state grant is expended. Wadena
 542.22 County must outline the proposed funding
 542.23 stream or mechanism, and any necessary local
 542.24 funding commitment, which will ensure the
 542.25 program will result in a sustainable program.
 542.26 The funding stream may include state funding
 542.27 for programs and services for which the
 542.28 individuals served under this paragraph may
 542.29 be eligible. The commissioner of human
 542.30 services, in collaboration with Wadena
 542.31 County, may explore a plan for continued
 542.32 funding using existing appropriations through
 542.33 eligibility for group residential housing under
 542.34 Minnesota Statutes, chapter 256I.
 542.35 The peer-run respite center must:

- 543.1 (1) admit individuals who are in need of peer
543.2 support and supportive services while
543.3 addressing an increase in symptoms or
543.4 stressors or exacerbation of their mental health
543.5 or substance abuse;
- 543.6 (2) admit individuals to reside at the center on
543.7 a short-term basis, no longer than five days;
- 543.8 (3) be operated by a nonprofit organization;
- 543.9 (4) employ individuals who have personal
543.10 experience with mental health or co-occurring
543.11 substance abuse conditions who meet the
543.12 qualifications of a mental health certified peer
543.13 specialist under Minnesota Statutes, section
543.14 256B.0615, or a recovery peer;
- 543.15 (5) provide at least three but no more than six
543.16 beds in private rooms; and
- 543.17 (6) not provide clinical services.
- 543.18 By November 1, 2018, the commissioner of
543.19 human services, in consultation with Wadena
543.20 County, shall report to the committees in the
543.21 senate and house of representatives with
543.22 jurisdiction over mental health issues, the
543.23 status of planning and development of the
543.24 peer-run respite center, and the plan to
543.25 financially support the program and services
543.26 after the state grant is expended.
- 543.27 **(b) Housing Options for Persons with**
543.28 **Serious Mental Illness.** \$1,250,000 in fiscal
543.29 year 2018 and \$1,250,000 in fiscal year 2019
543.30 are from the general fund for adult mental
543.31 health grants under Minnesota Statutes, section
543.32 245.4661, subdivision 9, paragraph (a), clause
543.33 (2), to support increased availability of
543.34 housing options with supports for persons with

544.1 serious mental illness. This is a onetime
544.2 appropriation.

544.3 **(c) Assertive Community Treatment.**
544.4 \$500,000 in fiscal year 2018 and \$500,000 in
544.5 fiscal year 2019 are from the general fund for
544.6 adult mental health grants under Minnesota
544.7 Statutes, section 256B.0622, subdivision 12,
544.8 to expand assertive community treatment
544.9 services. This is a onetime appropriation.

544.10 **(d) Mental Health Crisis Services.**
544.11 \$1,000,000 in fiscal year 2018 and \$1,000,000
544.12 in fiscal year 2019 are from the general fund
544.13 for adult mental health grants under Minnesota
544.14 Statutes, section 245.4661, and children's
544.15 mental health grants under Minnesota Statutes,
544.16 section 245.4889, to expand mental health
544.17 crisis services, including:

544.18 (1) mobile crisis services;
544.19 (2) residential crisis services;
544.20 (3) colocation of mobile crisis services in
544.21 urgent care clinics and psychiatric emergency
544.22 departments; and
544.23 (4) development of co-responder mental health
544.24 crisis response models.

544.25 This is a onetime appropriation.

544.26 **(e) Housing with Supports.** \$750,000 in fiscal
544.27 year 2018 and \$750,000 in fiscal year 2019
544.28 are for the housing with supports for adults
544.29 with serious mental illness grant under
544.30 Minnesota Statutes, section 245.4661,
544.31 subdivision 9, paragraph (a), clause (2). This
544.32 is a onetime appropriation.

545.1 (f) **Base Level Adjustment.** The general fund
 545.2 base is \$79,802,000 in fiscal year 2020 and
 545.3 \$79,802,000 in fiscal year 2021.

545.4 Subd. 31. **Grant Programs; Child Mental Health**
 545.5 **Grants**

23,050,000

22,458,000

545.6 (a) **Children's Mental Health Collaborative**

545.7 **Grants.** \$600,000 in fiscal year 2018 and
 545.8 \$600,000 in fiscal year 2019 are for a grant
 545.9 for a rural multicounty demonstration project
 545.10 to assist transition-aged youth and young
 545.11 adults with emotional behavioral disturbance
 545.12 or mental illnesses in making a successful
 545.13 transition into adulthood. This is a onetime
 545.14 appropriation.

545.15 Children's mental health collaboratives under
 545.16 Minnesota Statutes, section 245.493, are
 545.17 eligible to apply for the grant under this
 545.18 paragraph. The commissioner shall solicit
 545.19 proposals and award the grant to one proposal
 545.20 that best meets the requirement that a
 545.21 demonstration project must:

545.22 (1) build on and streamline transition services
 545.23 by identifying rural youth 15 to 25 years of
 545.24 age currently in the mental health system or
 545.25 with emerging mental health conditions;

545.26 (2) support youth to achieve, within the youth's
 545.27 potential, personal goals in employment,
 545.28 education, housing, and community life
 545.29 functioning;

545.30 (3) provide individualized motivational
 545.31 coaching;

545.32 (4) build on needed social supports;

545.33 (5) demonstrate how services can be enhanced
 545.34 for youth to successfully navigate the

- 546.1 complexities associated with their unique
546.2 needs;
- 546.3 (6) use all available funding streams;
- 546.4 (7) demonstrate collaboration with the local
546.5 children's mental health collaborative in
546.6 designing and implementing the demonstration
546.7 project;
- 546.8 (8) evaluate the effectiveness of the project
546.9 by specifying and measuring outcomes
546.10 showing the level of progress for involved
546.11 youth; and
- 546.12 (9) compare differences in outcomes and costs
546.13 to youth without previous access to this
546.14 project.
- 546.15 By January 15, 2019, the commissioner shall
546.16 report to the legislative committees with
546.17 jurisdiction over mental health issues on the
546.18 status and outcomes of the demonstration
546.19 project. The children's mental health
546.20 collaborative administering the demonstration
546.21 project shall collect and report outcome data,
546.22 as requested by the commissioner, to support
546.23 the development of the report.
- 546.24 **(b) First Psychotic Episode Funding.**
546.25 \$750,000 in fiscal year 2018 and \$750,000 in
546.26 fiscal year 2019 are for grants under
546.27 Minnesota Statutes, section 245.4889,
546.28 subdivision 1, paragraph (b), clause (15).
546.29 Funding shall be used to:
- 546.30 (1) provide intensive treatment and supports
546.31 to adolescents and adults experiencing or at
546.32 risk of a first psychotic episode. Intensive
546.33 treatment and support includes medication
546.34 management, psychoeducation for the

547.1 individual and family, case management,
547.2 employment supports, education supports,
547.3 cognitive behavioral approaches, social skills
547.4 training, peer support, crisis planning, and
547.5 stress management. Projects must use all
547.6 available funding streams;

547.7 (2) conduct outreach, training, and guidance
547.8 to mental health and health care professionals,
547.9 including postsecondary health clinics, on
547.10 early psychosis symptoms, screening tools,
547.11 and best practices; and

547.12 (3) ensure access to first psychotic episode
547.13 psychosis services under this section,
547.14 including ensuring access for individuals who
547.15 live in rural areas. Funds may be used to pay
547.16 for housing or travel or to address other
547.17 barriers to individuals and their families
547.18 participating in first psychotic episode
547.19 services.

547.20 **(c) Children's School-Linked Mental Health**
547.21 **Grants.** \$2,000,000 in fiscal year 2018 and
547.22 \$2,000,000 in fiscal year 2019 are for
547.23 children's school-linked mental health grants
547.24 under Minnesota Statutes, section 245.4889,
547.25 subdivision 1, paragraph (b), clause (8), to
547.26 expand services to school districts or counties
547.27 in which school-linked mental health services
547.28 are not available and to fund transportation
547.29 for children using school-linked mental health
547.30 services when school is not in session. The
547.31 commissioner shall require grantees to use all
547.32 available third-party reimbursement sources
547.33 as a condition of the receipt of grant funds.
547.34 For purposes of this appropriation, a
547.35 third-party reimbursement source does not

548.1 include a public school under Minnesota
548.2 Statutes, section 120A.20, subdivision 1.

548.3 **(d) Respite Care Services. \$282,000 in fiscal**
548.4 **year 2018 and \$282,000 in fiscal year 2019**
548.5 **are for children's mental health grants under**
548.6 **Minnesota Statutes, section 245.4889,**
548.7 **subdivision 1, paragraph (b), clause (3), to**
548.8 **provide respite care services to families of**
548.9 **children with serious mental illness. This is a**
548.10 **onetime appropriation.**

548.11 **(e) Text Message Suicide Prevention and**
548.12 **Mental Health Crisis Response Program.**
548.13 **\$657,000 in fiscal year 2018 is from the**
548.14 **general fund for a grant to a nonprofit to make**
548.15 **the text message suicide prevention and mental**
548.16 **health crisis response program available**
548.17 **statewide. This is a onetime appropriation.**
548.18 **The nonprofit shall use grant funds to:**

548.19 **(1) operate the text message suicide prevention**
548.20 **and mental health crisis response program**
548.21 **statewide and provide a method of response**
548.22 **that triages inquiries, provides immediate**
548.23 **access to suicide prevention and crisis**
548.24 **counseling over the telephone or via text**
548.25 **messaging, and provides individual, family,**
548.26 **or community education;**

548.27 **(2) connect individuals with trained crisis**
548.28 **counselors and access to local resources,**
548.29 **including referrals to community mental health**
548.30 **options, emergency departments, and locally**
548.31 **available mobile crisis teams, when**
548.32 **appropriate;**

548.33 **(3) maximize availability of services and**
548.34 **access across the state, in conjunction with**

549.1 other suicide prevention programs and
 549.2 services; and
 549.3 (4) provide community education on the
 549.4 availability of the program and how to access
 549.5 the program.

549.6 **(f) Base Level Adjustment.** The general fund
 549.7 base is \$20,826,000 in fiscal year 2020 and
 549.8 \$20,826,000 in fiscal year 2021.

549.9 **Subd. 32. Grant Programs; Chemical**
 549.10 **Dependency Treatment Support Grants**

549.11	<u>Appropriations by Fund</u>		
549.12	<u>General</u>	<u>2,636,000</u>	<u>2,636,000</u>
549.13	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

549.14 **(a) Problem Gambling.** \$225,000 in fiscal
 549.15 year 2018 and \$225,000 in fiscal year 2019
 549.16 are from the lottery prize fund for a grant to
 549.17 the state affiliate recognized by the National
 549.18 Council on Problem Gambling. The affiliate
 549.19 must provide services to increase public
 549.20 awareness of problem gambling, education,
 549.21 and training for individuals and organizations
 549.22 providing effective treatment services to
 549.23 problem gamblers and their families, and
 549.24 research related to problem gambling.

549.25 **(b) Minnesota Organization on Fetal**
 549.26 **Alcohol Syndrome.** \$500,000 in fiscal year
 549.27 2018 and \$500,000 in fiscal year 2019 are for
 549.28 a grant to the Minnesota Organization on Fetal
 549.29 Alcohol Syndrome (MOFAS). This is a
 549.30 onetime appropriation. Of this amount,
 549.31 MOFAS shall make grants to eligible regional
 549.32 collaboratives that fulfill the requirements in
 549.33 this paragraph. "Eligible regional
 549.34 collaboratives" means a partnership between
 549.35 at least one local government and at least one

550.1 community-based organization and, where
550.2 available, a family home visiting program. For
550.3 purposes of this paragraph, a local government
550.4 includes a county or multicounty organization,
550.5 a tribal government, a county-based
550.6 purchasing entity, or a community health
550.7 board. Eligible regional collaboratives must
550.8 use grant funds to reduce the incidence of fetal
550.9 alcohol syndrome disorders and other prenatal
550.10 drug-related effects in children in Minnesota
550.11 by identifying and serving pregnant women
550.12 suspected of or known to use or abuse alcohol
550.13 or other drugs. The eligible regional
550.14 collaboratives must provide intensive services
550.15 to chemically dependent women to increase
550.16 positive birth outcomes. MOFAS must make
550.17 grants to eligible regional collaboratives from
550.18 both rural and urban areas. A grant recipient
550.19 must report to the commissioner of human
550.20 services annually by January 15 on the
550.21 services and programs funded by the
550.22 appropriation. The report must include
550.23 measurable outcomes for the previous year,
550.24 including the number of pregnant women
550.25 served and the number of toxic-free babies
550.26 born.

550.27 (c) **Base Level Adjustment.** The general fund
550.28 base is \$2,136,000 in fiscal year 2020 and
550.29 \$2,136,000 in fiscal year 2021.

550.30 Subd. 33. **Direct Care and Treatment - Generally**

550.31 (a) **Transfer Authority.** Money appropriated
550.32 to budget activities under subdivisions 34, 35,
550.33 36, 37, and 38 may be transferred between
550.34 budget activities and between years of the

551.1 biennium with the approval of the
551.2 commissioner of management and budget.

551.3 **(b) Dedicated Receipts Available.** Of the
551.4 revenue received under Minnesota Statutes,
551.5 section 246.18, subdivision 8, paragraph (a),
551.6 up to \$1,000,000 each year is available for the
551.7 purposes of Minnesota Statutes, section
551.8 246.18, subdivision 8, paragraph (b), clause
551.9 (1); and up to \$2,713,000 each year is
551.10 available for the purposes of Minnesota
551.11 Statutes, section 246.18, subdivision 8,
551.12 paragraph (b), clause (2).

551.13 **Subd. 34. Direct Care and Treatment - Mental**
551.14 **Health and Substance Abuse** 114,521,000 114,607,000

551.15 **(a) Child and Adolescent Behavioral Health**
551.16 **Services.** \$405,000 in fiscal year 2018 and
551.17 \$491,000 in fiscal year 2019 are to continue
551.18 to operate the child and adolescent behavioral
551.19 health services program under Minnesota
551.20 Statutes, section 246.014. This is a onetime
551.21 appropriation.

551.22 **(b) Base Level Adjustment.** The general fund
551.23 base is \$114,116,000 in fiscal year 2020 and
551.24 \$114,116,000 in fiscal year 2021.

551.25 **Subd. 35. Direct Care and Treatment -**
551.26 **Community-Based Services** 15,298,000 15,298,000

551.27 **Subd. 36. Direct Care and Treatment - Forensic**
551.28 **Services** 91,658,000 91,675,000

551.29 **Subd. 37. Direct Care and Treatment - Sex**
551.30 **Offender Program** 86,731,000 86,731,000

551.31 **Transfer Authority.** Money appropriated for
551.32 the Minnesota sex offender program may be
551.33 transferred between fiscal years of the
551.34 biennium with the approval of the
551.35 commissioner of management and budget.

552.1	<u>Subd. 38. Direct Care and Treatment -</u>			
552.2	<u>Operations</u>		<u>42,744,000</u>	<u>42,744,000</u>
552.3	<u>Subd. 39. Technical Activities</u>		<u>86,186,000</u>	<u>86,339,000</u>
552.4	<u>(a) This appropriation is from the federal</u>			
552.5	<u>TANF fund.</u>			
552.6	<u>(b) Base Level Adjustment. The TANF fund</u>			
552.7	<u>base is \$86,346,000 in fiscal year 2020 and</u>			
552.8	<u>\$86,355,000 in fiscal year 2021.</u>			
552.9	<u>Sec. 3. COMMISSIONER OF HEALTH</u>			
552.10	<u>Subdivision 1. Total Appropriation</u>		<u>\$ 206,445,000</u>	<u>\$ 198,015,000</u>
552.11	<u>Appropriations by Fund</u>			
552.12		<u>2018</u>	<u>2019</u>	
552.13	<u>General</u>	<u>105,966,000</u>	<u>98,389,000</u>	
552.14	<u>State Government</u>			
552.15	<u>Special Revenue</u>	<u>52,356,000</u>	<u>52,090,000</u>	
552.16	<u>Health Care Access</u>	<u>37,566,000</u>	<u>36,979,000</u>	
552.17	<u>Federal TANF</u>	<u>10,557,000</u>	<u>10,557,000</u>	
552.18	<u>The amounts that may be spent for each</u>			
552.19	<u>purpose are specified in the following</u>			
552.20	<u>subdivisions.</u>			
552.21	<u>Subd. 2. Health Improvement</u>			
552.22	<u>Appropriations by Fund</u>			
552.23	<u>General</u>	<u>83,839,000</u>	<u>76,336,000</u>	
552.24	<u>State Government</u>			
552.25	<u>Special Revenue</u>	<u>6,215,000</u>	<u>6,182,000</u>	
552.26	<u>Health Care Access</u>	<u>37,566,000</u>	<u>36,979,000</u>	
552.27	<u>Federal TANF</u>	<u>10,557,000</u>	<u>10,557,000</u>	
552.28	<u>(a) TANF Appropriations. (1) \$3,579,000</u>			
552.29	<u>of the TANF fund each year is for home</u>			
552.30	<u>visiting and nutritional services listed under</u>			
552.31	<u>Minnesota Statutes, section 145.882,</u>			
552.32	<u>subdivision 7, clauses (6) and (7). Funds must</u>			
552.33	<u>be distributed to community health boards</u>			
552.34	<u>according to Minnesota Statutes, section</u>			
552.35	<u>145A.131, subdivision 1.</u>			

- 553.1 (2) \$2,000,000 of the TANF fund each year
553.2 is for decreasing racial and ethnic disparities
553.3 in infant mortality rates under Minnesota
553.4 Statutes, section 145.928, subdivision 7.
- 553.5 (3) \$4,978,000 of the TANF fund each year
553.6 is for the family home visiting grant program
553.7 according to Minnesota Statutes, section
553.8 145A.17. \$4,000,000 of the funding must be
553.9 distributed to community health boards
553.10 according to Minnesota Statutes, section
553.11 145A.131, subdivision 1. \$978,000 of the
553.12 funding must be distributed to tribal
553.13 governments according to Minnesota Statutes,
553.14 section 145A.14, subdivision 2a.
- 553.15 (4) The commissioner may use up to 6.23
553.16 percent of the funds appropriated each year to
553.17 conduct the ongoing evaluations required
553.18 under Minnesota Statutes, section 145A.17,
553.19 subdivision 7, and training and technical
553.20 assistance as required under Minnesota
553.21 Statutes, section 145A.17, subdivisions 4 and
553.22 5.
- 553.23 (b) TANF Carryforward. Any unexpended
553.24 balance of the TANF appropriation in the first
553.25 year of the biennium does not cancel but is
553.26 available for the second year.
- 553.27 (c) Evidence-Based Home Visiting.
553.28 \$1,500,000 in fiscal year 2018 and \$1,500,000
553.29 in fiscal year 2019 are from the general fund
553.30 to provide start-up and expansion grants to
553.31 community health boards, nonprofit
553.32 organizations, and tribal nations to start up or
553.33 expand evidence-based home visiting
553.34 programs. Grant funds must be used to start
553.35 up or expand evidence-based home visiting

554.1 programs in the county, reservation, or region
554.2 to serve families, such as parents with high
554.3 risk or high needs, parents with a history of
554.4 mental illness, domestic abuse, or substance
554.5 abuse, or first-time mothers prenatally until
554.6 the child is four years of age, who are eligible
554.7 for medical assistance under Minnesota
554.8 Statutes, chapter 256B, or the federal Special
554.9 Supplemental Nutrition Program for Women,
554.10 Infants, and Children. The commissioner shall
554.11 award grants to community health boards,
554.12 nonprofits, or tribal nations in metropolitan
554.13 and rural areas of the state. Priority for grants
554.14 to rural areas shall be given to community
554.15 health boards, nonprofits, and tribal nations
554.16 that expand services within regional
554.17 partnerships that provide the evidence-based
554.18 home visiting programs. This funding shall
554.19 only be used to supplement, not to replace,
554.20 funds being used for evidence-based home
554.21 visiting services as of June 30, 2017. The
554.22 general fund base for these grants is \$750,000
554.23 in fiscal year 2020 and \$750,000 in fiscal year
554.24 2021.

554.25 **(d) Safe Harbor for Sexually Exploited**
554.26 **Youth Services.** \$325,000 in fiscal year 2018
554.27 **and \$325,000 in fiscal year 2019 are from the**
554.28 **general fund for trauma-informed, culturally**
554.29 **specific services for sexually exploited youth.**
554.30 **Youth 24 years of age or younger are eligible**
554.31 **for services under this paragraph.**

554.32 **(e) Safe Harbor Program Technical**
554.33 **Assistance and Evaluation.** \$225,000 in
554.34 **fiscal year 2018 and \$225,000 in fiscal year**
554.35 **2019 are from the general fund for training,**

555.1 technical assistance, protocol implementation,
555.2 and evaluation activities related to the safe
555.3 harbor program. Of these amounts:

555.4 (1) \$100,000 each fiscal year is for providing
555.5 training and technical assistance to individuals
555.6 and organizations that provide safe harbor
555.7 services and receive funds for that purpose
555.8 from the commissioner of human services or
555.9 commissioner of health;

555.10 (2) \$100,000 each fiscal year is for protocol
555.11 implementation, which includes providing
555.12 technical assistance in establishing best
555.13 practices-based systems for effectively
555.14 identifying, interacting with, and referring
555.15 sexually exploited youth to appropriate
555.16 resources; and

555.17 (3) \$25,000 each fiscal year is for program
555.18 evaluation activities in compliance with
555.19 Minnesota Statutes, section 145.4718.

555.20 **(f) Promoting Safe Harbor Capacity. In**
555.21 **funding services and activities under**
555.22 **paragraphs (d) and (e), the commissioner shall**
555.23 **emphasize activities that promote**
555.24 **capacity-building and development of**
555.25 **resources in greater Minnesota.**

555.26 **(g) Administration of Safe Harbor**
555.27 **Program. \$60,000 in fiscal year 2018 and**
555.28 **\$60,000 in fiscal year 2019 are for**
555.29 **administration of the safe harbor for sexually**
555.30 **exploited youth program.**

555.31 **(h) Palliative Care Advisory Council.**
555.32 **\$44,000 in fiscal year 2018 and \$44,000 in**
555.33 **fiscal year 2019 are from the general fund for**

556.1 the Palliative Care Advisory Council under
556.2 Minnesota Statutes, section 144.059.

556.3 **(i) Grants for Drug Deactivation and**
556.4 **Disposal. \$500,000 in fiscal year 2018 and**
556.5 **\$500,000 in fiscal year 2019 are from the**
556.6 **general fund to provide grants to pharmacists**
556.7 **and other prescription drug dispensers, local**
556.8 **public health and human services agencies,**
556.9 **local law enforcement, health care providers,**
556.10 **and other entities to purchase**
556.11 **omni-degradable, at-home prescription drug**
556.12 **deactivation and disposal products to assist**
556.13 **the public in the disposal of prescription drugs**
556.14 **in a safe, environmentally sound manner. A**
556.15 **grant recipient must provide these deactivation**
556.16 **and disposal products free of charge to**
556.17 **members of the public. This is a onetime**
556.18 **appropriation.**

556.19 **(j) Early Dental Disease Prevention Pilot**
556.20 **Program. \$500,000 in fiscal year 2018 and**
556.21 **\$500,000 in fiscal year 2019 are from the**
556.22 **general fund for early dental disease**
556.23 **prevention and awareness activities under**
556.24 **Minnesota Statutes, section 144.061. This is**
556.25 **a onetime appropriation. Funding shall be used**
556.26 **to:**

556.27 **(1) award grants to five designated**
556.28 **communities of color or communities of recent**
556.29 **immigrants to participate in a pilot program**
556.30 **to increase awareness and encourage early**
556.31 **preventive dental disease intervention for**
556.32 **infants and toddlers. At least two of the**
556.33 **designated communities receiving grants under**
556.34 **this clause must be located outside the**
556.35 **seven-county metropolitan area;**

557.1 (2) in consultation with members of the
557.2 designated communities, distribute or cause
557.3 to be distributed the educational materials
557.4 developed under Minnesota Statutes, section
557.5 144.061, paragraph (b), to expectant and new
557.6 parents within the designated communities.
557.7 The materials shall be distributed as provided
557.8 in Minnesota Statutes, section 144.061,
557.9 paragraph (c), and through a variety of
557.10 communicative means, including oral, visual,
557.11 audio, and print. The commissioner shall assist
557.12 designated communities with developing
557.13 strategies, including outreach through ethnic
557.14 radio, Webcasts, and local cable programs,
557.15 and incentives to ensure the educational
557.16 materials and information are distributed and
557.17 to encourage and provide early preventive
557.18 dental disease intervention and care for infants
557.19 and toddlers that are geared toward the ethnic
557.20 groups residing in the designated community;
557.21 (3) develop measurable outcomes, establish a
557.22 baseline measurement, and evaluate
557.23 performance within each designated
557.24 community to measure whether the
557.25 educational materials, information, strategies,
557.26 and incentives increased the number of infants
557.27 and toddlers receiving early preventative
557.28 dental disease intervention and care; and
557.29 (4) by March 15, 2019, report to the chairs
557.30 and ranking minority members of the
557.31 legislative committees with jurisdiction over
557.32 health care on the details of the program
557.33 funded under this paragraph, communities
557.34 designated for the program, strategies and any

558.1 incentives implemented, and the results of the
558.2 evaluation for each designated community.

558.3 **(k) Minnesota Biomedicine and Bioethics**
558.4 **Innovation Grants. \$5,000,000 in fiscal year**
558.5 **2018 is from the general fund for Minnesota**
558.6 **biomedicine and bioethics innovation grants**
558.7 **under Minnesota Statutes, section 144.88. This**
558.8 **is a onetime appropriation and is available**
558.9 **until June 30, 2021.**

558.10 **(l) Statewide Strategic Plan for Victims of**
558.11 **Sex Trafficking. \$73,000 in fiscal year 2018**
558.12 **is from the general fund for the development**
558.13 **of a comprehensive statewide strategic plan**
558.14 **and report to address the needs of sex**
558.15 **trafficking victims statewide. This is a onetime**
558.16 **appropriation.**

558.17 **(m) Statewide Tobacco Quitline Service. Of**
558.18 **the health care access fund appropriation for**
558.19 **the statewide health improvement program,**
558.20 **\$461,000 in fiscal year 2018 and \$2,969,000**
558.21 **in fiscal year 2019 are for administering or**
558.22 **contracting for the administration of the**
558.23 **statewide tobacco quitline service established**
558.24 **under Minnesota Statutes, section 144.397.**

558.25 **(n) Home and Community-Based Services**
558.26 **Employee Scholarship Program. \$1,000,000**
558.27 **in fiscal year 2018 and \$1,000,000 in fiscal**
558.28 **year 2019 are from the general fund for the**
558.29 **home and community-based services**
558.30 **employee scholarship program under**
558.31 **Minnesota Statutes, section 144.1503.**

558.32 **(o) Comprehensive Advanced Life Support**
558.33 **Educational Program. \$100,000 in fiscal**
558.34 **year 2018 and \$100,000 in fiscal year 2019**

559.1 are from the general fund for the
559.2 comprehensive advanced life support
559.3 educational program under Minnesota Statutes,
559.4 section 144.6062. This is a onetime
559.5 appropriation.

559.6 **(p) Senior Care Workforce Innovation**
559.7 **Grant Program. \$1,000,000 in fiscal year**
559.8 **2018 and \$1,000,000 in fiscal year 2019 are**
559.9 **from the general fund for the senior care**
559.10 **workforce innovation grant program under**
559.11 **Minnesota Statutes, section 144.1504.**

559.12 **(q) Physician Residency Expansion Grant**
559.13 **Program. \$1,500,00 in fiscal year 2018 and**
559.14 **\$1,500,000 in fiscal 2019 are from the health**
559.15 **care access fund for the physician residency**
559.16 **expansion grant program under Minnesota**
559.17 **Statutes, section 144.1506.**

559.18 **(r) Opioid Abuse Prevention. \$2,028,000 in**
559.19 **fiscal year 2018 is to establish accountable**
559.20 **community for health opioid abuse prevention**
559.21 **pilot projects. \$28,000 of this amount is for**
559.22 **administration. This is a onetime**
559.23 **appropriation.**

559.24 **(s) Opioid Prescriber Education. \$535,000**
559.25 **in fiscal year 2018 and \$535,000 in fiscal year**
559.26 **2019 are for opioid prescriber education and**
559.27 **public awareness grants under Minnesota**
559.28 **Statutes, section 145.9263. \$35,000 in fiscal**
559.29 **year 2018 and \$35,000 in fiscal year 2019 are**
559.30 **for administration.**

559.31 **(t) Advanced Care Planning. \$500,000 in**
559.32 **fiscal year 2018 and \$500,000 in fiscal year**
559.33 **2019 are from the general fund for a grant to**
559.34 **a statewide advanced care planning resource**

560.1 organization that has expertise in convening
560.2 and coordinating community-based strategies
560.3 to encourage individuals, families, caregivers,
560.4 and health care providers to begin
560.5 conversations regarding end-of-life care
560.6 choices that express an individual's health care
560.7 values and preferences and are based on
560.8 informed health care decisions. Of this
560.9 amount, \$9,000 each year is for administration.

560.10 **(u) Health Professionals Clinical Training**
560.11 **Expansion Grant Program. \$1,000,000 in**
560.12 **fiscal year 2018 and \$1,000,000 in fiscal year**
560.13 **2019 are from the general fund for the primary**
560.14 **care and mental health professions clinical**
560.15 **training expansion grant program under**
560.16 **Minnesota Statutes, section 144.1505.**

560.17 **(v) Youth Sports Concussion Working**
560.18 **Group and Brain Health Pilot Programs.**
560.19 **\$450,000 in fiscal year 2018 is from the**
560.20 **general fund for the youth sports concussion**
560.21 **working group and brain health pilot**
560.22 **programs. This is a onetime appropriation. Of**
560.23 **this appropriation:**

560.24 **(1) \$150,000 is for the youth sports concussion**
560.25 **working group, including any required**
560.26 **incidence research; and**

560.27 **(2) \$300,000 is for the brain health pilot**
560.28 **programs.**

560.29 **(w) Base Level Adjustments. The general**
560.30 **fund base is \$74,436,000 in fiscal year 2020**
560.31 **and \$74,486,000 in fiscal year 2021. The**
560.32 **health care access fund base is \$37,579,000**
560.33 **in fiscal year 2020 and \$36,979,000 in fiscal**
560.34 **year 2021.**

561.1 Subd. 3. Health Protection561.2 Appropriations by Fund561.3 General 14,552,000 14,478,000561.4 State Government561.5 Special Revenue 46,141,000 45,908,000561.6 (a) Prescribed Pediatric Extended Care561.7 Center Licensure Activities. \$64,000 in fiscal561.8 year 2018 and \$17,000 in fiscal year 2019 are561.9 from the state government special revenue561.10 fund for licensure of prescribed pediatric561.11 extended care centers under Minnesota561.12 Statutes, chapter 144H.561.13 (b) Vulnerable Adults in Health Care561.14 Settings. \$633,000 in fiscal year 2018 and561.15 \$559,000 in fiscal year 2019 are from the561.16 general fund for regulating health care and561.17 home care settings.561.18 (c) Base Level Adjustment. The general fund561.19 base is \$14,867,000 in fiscal year 2020 and561.20 \$14,777,000 in fiscal year 2021. The state561.21 government special revenue fund base is561.22 \$45,881,000 in fiscal year 2020 and561.23 \$45,873,000 in fiscal year 2021.561.24 Subd. 4. Health Operations

7,575,000

7,575,000

561.25 Sec. 4. HEALTH-RELATED BOARDS561.26 Subdivision 1. Total Appropriation

\$

24,986,000

\$

23,279,000

561.27 This appropriation is from the state561.28 government special revenue fund. The561.29 amounts that may be spent for each purpose561.30 are specified in the following subdivisions.561.31 Subd. 2. Board of Chiropractic Examiners

565,000

571,000

562.1	<u>Base Level Adjustment.</u> The base is \$576,000		
562.2	<u>in fiscal year 2020 and \$576,000 in fiscal year</u>		
562.3	<u>2021.</u>		
562.4	<u>Subd. 3. Board of Dentistry</u>	<u>1,396,000</u>	<u>1,408,000</u>
562.5	<u>Subd. 4. Board of Dietetics and Nutrition</u>		
562.6	<u>Practice</u>	<u>130,000</u>	<u>132,000</u>
562.7	<u>Subd. 5. Board of Marriage and Family Therapy</u>	<u>360,000</u>	<u>357,000</u>
562.8	<u>Base Level Adjustment.</u> The base is \$360,000		
562.9	<u>in fiscal year 2020 and \$362,000 in fiscal year</u>		
562.10	<u>2021.</u>		
562.11	<u>Subd. 6. Board of Medical Practice</u>	<u>5,194,000</u>	<u>5,330,000</u>
562.12	<u>This appropriation includes \$964,000 in fiscal</u>		
562.13	<u>year 2018 and \$964,000 in fiscal year 2019</u>		
562.14	<u>for the health professional services program.</u>		
562.15	<u>The base for this program is \$924,000 in fiscal</u>		
562.16	<u>year 2020 and \$924,000 in fiscal year 2021.</u>		
562.17	<u>Base Level Adjustment.</u> The base is		
562.18	<u>\$5,292,000 in fiscal year 2020 and \$5,292,000</u>		
562.19	<u>in fiscal year 2021.</u>		
562.20	<u>Subd. 7. Board of Nursing</u>	<u>6,380,000</u>	<u>4,783,000</u>
562.21	<u>Subd. 8. Board of Nursing Home Administrators</u>	<u>3,397,000</u>	<u>3,202,000</u>
562.22	<u>(a) Administrative Services Unit - Operating</u>		
562.23	<u>Costs.</u> Of this appropriation, \$2,260,000 in		
562.24	<u>fiscal year 2018 and \$2,287,000 in fiscal year</u>		
562.25	<u>2019 are for operating costs of the</u>		
562.26	<u>administrative services unit. The</u>		
562.27	<u>administrative services unit may receive and</u>		
562.28	<u>expend reimbursements for services it</u>		
562.29	<u>performs for other agencies.</u>		
562.30	<u>(b) Administrative Services Unit - Volunteer</u>		
562.31	<u>Health Care Provider Program.</u> Of this		
562.32	<u>appropriation, \$150,000 in fiscal year 2018</u>		
562.33	<u>and \$150,000 in fiscal year 2019 are to pay</u>		
562.34	<u>for medical professional liability coverage</u>		

563.1 required under Minnesota Statutes, section
563.2 214.40.

563.3 **(c) Administrative Services Unit -**
563.4 **Retirement Costs.** Of this appropriation,
563.5 \$378,000 in fiscal year 2019 is a onetime
563.6 appropriation to the administrative services
563.7 unit to pay for the retirement costs of
563.8 health-related board employees. This funding
563.9 may be transferred to the health board
563.10 incurring retirement costs. Any board that has
563.11 an unexpended balance for an amount
563.12 transferred under this paragraph shall transfer
563.13 the unexpended amount to the administrative
563.14 services unit. These funds are available either
563.15 year of the biennium.

563.16 **(d) Administrative Services Unit -**
563.17 **Health-Related Licensing Boards Operating**
563.18 **Costs.** Of this appropriation, \$194,000 in
563.19 fiscal year 2018 and \$350,000 in fiscal year
563.20 2019 shall be transferred to the health-related
563.21 boards funded under this section for operating
563.22 costs. The administrative services unit shall
563.23 determine transfer amounts in consultation
563.24 with the health-related boards funded under
563.25 this section.

563.26 **(e) Administrative Services Unit - Contested**
563.27 **Cases and Other Legal Proceedings.** Of this
563.28 appropriation, \$200,000 in fiscal year 2018
563.29 and \$200,000 in fiscal year 2019 are for costs
563.30 of contested case hearings and other
563.31 unanticipated costs of legal proceedings
563.32 involving health-related boards funded under
563.33 this section. Upon certification by a
563.34 health-related board to the administrative
563.35 services unit that costs will be incurred and

564.1 that there is insufficient money available to
 564.2 pay for the costs out of money currently
 564.3 available to that board, the administrative
 564.4 services unit is authorized to transfer money
 564.5 from this appropriation to the board for
 564.6 payment of those costs with the approval of
 564.7 the commissioner of management and budget.
 564.8 The commissioner of management and budget
 564.9 must require any board that has an unexpended
 564.10 balance for an amount transferred under this
 564.11 paragraph to transfer the unexpended amount
 564.12 to the administrative services unit to be
 564.13 deposited in the state government special
 564.14 revenue fund.

564.15 Subd. 9. Board of Optometry 156,000 157,000

564.16 Subd. 10. Board of Pharmacy 3,124,000 3,164,000

564.17 Base Level Adjustment. The base is
 564.18 \$3,189,000 in fiscal year 2020 and \$3,226,000
 564.19 in fiscal year 2021.

564.20 Subd. 11. Board of Physical Therapy 521,000 522,000

564.21 Base Level Adjustment. The base is \$524,000
 564.22 in fiscal year 2020 and \$526,000 in fiscal year
 564.23 2021.

564.24 Subd. 12. Board of Podiatric Medicine 204,000 204,000

564.25 Subd. 13. Board of Psychology 1,220,000 1,240,000

564.26 Base Level Adjustment. The base is
 564.27 \$1,247,000 in fiscal year 2020 and \$1,247,000
 564.28 in fiscal year 2021.

564.29 Subd. 14. Board of Social Work 1,254,000 1,246,000

564.30 Base Level Adjustment. The base is
 564.31 \$1,248,000 in fiscal year 2020 and \$1,250,000
 564.32 in fiscal year 2021.

564.33 Subd. 15. Board of Veterinary Medicine 314,000 320,000

565.1 **Base Level Adjustment.** The base is \$327,000
 565.2 in fiscal year 2020 and \$333,000 in fiscal year
 565.3 2021.

565.4 **Subd. 16. Board of Behavioral Health and**
 565.5 **Therapy**

771,000

643,000

565.6 **Subd. 17. Board of Occupational Therapy**
 565.7 **Practice**

374,000

328,000

565.8 **Sec. 5. EMERGENCY MEDICAL SERVICES**
 565.9 **REGULATORY BOARD**

\$

4,509,000

\$

4,438,000

565.10 **(a) Cooper/Sams Volunteer Ambulance**

565.11 **Program.** \$1,300,000 in fiscal year 2018 and

565.12 \$1,300,000 in fiscal year 2019 are for the

565.13 Cooper/Sams volunteer ambulance program

565.14 under Minnesota Statutes, section 144E.40.

565.15 The base for this program is \$700,000 in fiscal

565.16 year 2020 and \$700,000 in fiscal year 2021.

565.17 (1) Of this amount, \$1,211,000 in fiscal year

565.18 2018 and \$1,211,000 in fiscal year 2019 are

565.19 for the ambulance service personnel longevity

565.20 award and incentive program under Minnesota

565.21 Statutes, section 144E.40. The base for this

565.22 program is \$611,000 in fiscal year 2020 and

565.23 \$611,000 in fiscal year 2021.

565.24 (2) Of this amount, \$89,000 in fiscal year 2018

565.25 and \$89,000 in fiscal year 2019 are for the

565.26 operations of the ambulance service personnel

565.27 longevity award and incentive program under

565.28 Minnesota Statutes, section 144E.40.

565.29 **(b) EMSRB Board Operations.** \$1,360,000

565.30 in fiscal year 2018 and \$1,360,000 in fiscal

565.31 year 2019 are for board operations.

565.32 **(c) Regional Grants.** \$585,000 in fiscal year

565.33 2018 and \$585,000 in fiscal year 2019 are for

565.34 regional emergency medical services

566.1 programs, to be distributed equally to the eight
 566.2 emergency medical service regions under
 566.3 Minnesota Statutes, section 144E.50.

566.4 (d) Ambulance Training Grant. \$361,000
 566.5 in fiscal year 2018 and \$361,000 in fiscal year
 566.6 2019 are for training grants under Minnesota
 566.7 Statutes, section 144E.35.

566.8 (e) Base Level Adjustment. The base is
 566.9 \$3,840,000 in fiscal year 2020 and \$3,840,000
 566.10 in fiscal year 2021.

566.11	Sec. 6. <u>COUNCIL ON DISABILITY</u>	\$	<u>1,002,000</u>	\$	<u>1,002,000</u>
566.12	<u>Base Level Adjustment. The base is \$966,000</u>				
566.13	<u>in fiscal year 2020 and \$968,000 in fiscal year</u>				
566.14	<u>2021.</u>				

566.15	Sec. 7. <u>OMBUDSMAN FOR MENTAL</u>				
566.16	<u>HEALTH AND DEVELOPMENTAL</u>				
566.17	<u>DISABILITIES</u>	\$	<u>2,407,000</u>	\$	<u>2,427,000</u>
566.18	<u>Department of Psychiatry Monitoring.</u>				
566.19	<u>\$100,000 in fiscal year 2018 and \$100,000 in</u>				
566.20	<u>fiscal year 2019 are for monitoring the</u>				
566.21	<u>Department of Psychiatry at the University of</u>				
566.22	<u>Minnesota.</u>				

566.23	Sec. 8. <u>OMBUDSPERSONS FOR FAMILIES</u>	\$	<u>543,000</u>	\$	<u>551,000</u>
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566.24	Sec. 9. <u>COMMISSIONER OF COMMERCE</u>	\$	<u>1,194,000</u>	\$	<u>1,194,000</u>
566.25	<u>Base Level Adjustment. The base for this</u>				
566.26	<u>appropriation is \$1,194,000 in fiscal year 2020</u>				
566.27	<u>and \$594,000 in fiscal year 2021.</u>				

566.28 Sec. 10. Laws 2009, chapter 101, article 1, section 12, is amended to read:

566.29 Sec. 12. **ADMINISTRATION**

566.30	Subdivision 1. Total Appropriation	\$	19,973,000	\$	19,617,000
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566.31 Appropriations by Fund

567.1		2010	2011
567.2	General	19,723,000	19,617,000
567.3	Special Revenue		
567.4	Fund	250,000	0

567.5 The amounts that may be spent for each
 567.6 purpose are specified in the following
 567.7 subdivisions.

567.8	Subd. 2. Government and Citizen Services		18,097,000	17,766,000
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567.9 Appropriations by Fund

567.10	General	17,847,000	17,766,000
567.11	Special Revenue		
567.12	Fund	250,000	0

567.13 (a) \$802,000 the first year and \$802,000 the
 567.14 second year are for the Minnesota Geospatial
 567.15 Information Office. Of the total appropriation,
 567.16 \$10,000 per year is intended for preparation
 567.17 of township acreage data in Laws 2008,
 567.18 chapter 366, article 17, section 7, subdivision
 567.19 3.

567.20 (b) \$74,000 the first year and \$74,000 the
 567.21 second year are for the Council on
 567.22 Developmental Disabilities.

567.23 ~~(c) \$127,000 the first year and \$127,000 the~~
 567.24 ~~second year are for transfer to the~~
 567.25 ~~commissioner of human services for a grant~~
 567.26 ~~to the Council on Developmental Disabilities~~
 567.27 ~~for the purpose of establishing a statewide~~
 567.28 ~~self-advocacy network for persons with~~
 567.29 ~~intellectual and developmental disabilities~~
 567.30 ~~(ID/DD). The self-advocacy network shall:~~
 567.31 ~~(1) ensure that persons with ID/DD are~~
 567.32 ~~informed of their rights in employment,~~
 567.33 ~~housing, transportation, voting, government~~
 567.34 ~~policy, and other issues pertinent to the ID/DD~~
 567.35 ~~community; (2) provide public education and~~

568.1 ~~awareness of the civil and human rights issues~~
568.2 ~~persons with ID/DD face; (3) provide funds;~~
568.3 ~~technical assistance, and other resources for~~
568.4 ~~self-advocacy groups across the state; and (4)~~
568.5 ~~organize systems of communications to~~
568.6 ~~facilitate an exchange of information between~~
568.7 ~~self-advocacy groups. This appropriation must~~
568.8 ~~be included in the base budget for the~~
568.9 ~~commissioner of human services for the~~
568.10 ~~biennium beginning July 1, 2011.~~

568.11 (d) \$250,000 the first year and \$170,000 the
568.12 second year are to fund activities to prepare
568.13 for and promote the 2010 census.

568.14 (e) \$206,000 the first year and \$206,000 the
568.15 second year are for the Office of the State
568.16 Archaeologist.

568.17 (f) \$8,388,000 the first year and \$8,388,000
568.18 the second year are for office space costs of
568.19 the legislature and veterans organizations, for
568.20 ceremonial space, and for statutorily free
568.21 space.

568.22 (g) \$3,500,000 of the balance in the facilities
568.23 repair and replacement account in the special
568.24 revenue fund is canceled to the general fund
568.25 on July 1, 2009. This is a onetime cancellation.

568.26 (h) The requirements imposed on the
568.27 commissioner of finance and the commissioner
568.28 of administration under Laws 2007, chapter
568.29 148, article 1, section 12, subdivision 2,
568.30 paragraph (b), relating to the savings
568.31 attributable to the real property portfolio
568.32 management system are inoperative.

568.33 (i) \$250,000 is appropriated to the
568.34 commissioner of administration from the

569.1 information and telecommunications account
 569.2 in the special revenue fund to continue
 569.3 planning for data center consolidation,
 569.4 including beginning a predesign study and
 569.5 lifecycle cost analysis, and exploring
 569.6 technologies to reduce energy consumption
 569.7 and operating costs.

569.8 Subd. 3. Administrative Management Support	1,876,000	1,851,000
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569.9 \$125,000 each year is for the Office of Grant
 569.10 Management. During the biennium ending
 569.11 June 30, 2011, the commissioner must recover
 569.12 this amount through deductions in state grants
 569.13 subject to the jurisdiction of the office. The
 569.14 commissioner may not deduct more than 2.5
 569.15 percent from the amount of any grant. The
 569.16 amount deducted from appropriations for these
 569.17 grants must be deposited in the general fund.

569.18 \$25,000 the first year is for the Office of
 569.19 Grants Management to study and make
 569.20 recommendations on improving collaborative
 569.21 activities between the state, nonprofit entities,
 569.22 and the private sector, including: (1)
 569.23 recommendations for expanding successful
 569.24 initiatives involving not-for-profit
 569.25 organizations that have demonstrated
 569.26 measurable, positive results in addressing
 569.27 high-priority community issues; and (2)
 569.28 recommendations on grant requirements and
 569.29 design to encourage programs receiving grants
 569.30 to become self-sufficient. The office may
 569.31 appoint an advisory group to assist in the study
 569.32 and recommendations. The office must report
 569.33 its recommendations to the legislature by
 569.34 January 15, 2010.

570.1 Sec. 11. Laws 2012, chapter 247, article 6, section 2, subdivision 2, is amended to read:

570.2 Subd. 2. **Central Office Operations**

570.3	(a) Operations	118,000	356,000
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570.4 **Base Level Adjustment.** The general fund
570.5 base is increased by \$91,000 in fiscal year
570.6 2014 and \$44,000 in fiscal year 2015.

570.7	(b) Health Care	24,000	346,000
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570.8 This is a onetime appropriation.

570.9 **Managed Care Audit Activities.** In fiscal
570.10 year 2014, ~~and in each even-numbered year~~
570.11 ~~thereafter~~, the commissioner shall transfer
570.12 from the health care access fund \$1,740,000
570.13 to the legislative auditor for managed care
570.14 audit services under Minnesota Statutes,
570.15 section 256B.69, subdivision 9d. This is a
570.16 biennial appropriation. The health care access
570.17 fund base is increased by \$1,842,000 in fiscal
570.18 year 2014. ~~Notwithstanding any contrary~~
570.19 ~~provision in this article, this paragraph does~~
570.20 ~~not expire.~~

570.21	(c) Continuing Care	19,000	375,000
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570.22 **Base Level Adjustment.** The general fund
570.23 base is decreased by \$159,000 in fiscal years
570.24 2014 and 2015.

570.25 **EFFECTIVE DATE.** This section is effective the day following final enactment.

570.26 Sec. 12. Laws 2013, chapter 108, article 15, section 2, subdivision 2, is amended to read:

570.27 Subd. 2. **Central Office**

570.28 The amounts that may be spent from this
570.29 appropriation for each purpose are as follows:

570.30	(a) Operations	2,909,000	8,957,000
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571.1 **Base Adjustment.** The general fund base is
 571.2 decreased by \$8,916,000 in fiscal year 2016
 571.3 and \$8,916,000 in fiscal year 2017.

571.4	(b) Children and Families	109,000	206,000
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571.5	(c) Continuing Care	2,849,000	3,574,000
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571.6 **Base Adjustment.** The general fund base is
 571.7 decreased by \$2,000 in fiscal year 2016 and
 571.8 by \$27,000 in fiscal year 2017.

571.9	(d) Group Residential Housing	(1,166,000)	(8,602,000)
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571.10	(e) Medical Assistance	(3,950,000)	(6,420,000)
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571.11	(f) Alternative Care	(7,386,000)	(6,851,000)
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571.12	(g) Child and Community Service Grants	3,000,000	3,000,000
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571.13	(h) Aging and Adult Services Grants	5,365,000	5,936,000
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571.14 ~~**Gaps Analysis.** In fiscal year 2014, and in~~
 571.15 ~~each even-numbered year thereafter, \$435,000~~
 571.16 ~~is appropriated to conduct an analysis of gaps~~
 571.17 ~~in long-term care services under Minnesota~~
 571.18 ~~Statutes, section 144A.351. This is a biennial~~
 571.19 ~~appropriation. The base is increased by~~
 571.20 ~~\$435,000 in fiscal year 2016. Notwithstanding~~
 571.21 ~~any contrary provisions in this article, this~~
 571.22 ~~provision does not expire.~~

571.23 **Base Adjustment.** The general fund base is
 571.24 increased by \$498,000 in fiscal year 2016, and
 571.25 decreased by \$124,000 in fiscal year 2017.

571.26	(i) Disabilities Grants	414,000	414,000
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571.27 Sec. 13. Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended by Laws
 571.28 2015, First Special Session chapter 6, section 2, is amended to read:

571.29 **Subd. 2. Health Improvement**

571.30	Appropriations by Fund		
571.31	General	68,653,000	68,984,000
571.32	State Government		
571.33	Special Revenue	6,264,000	6,182,000

572.1 Health Care Access 33,987,000 33,421,000

572.2 Federal TANF 11,713,000 11,713,000

572.3 **Violence Against Asian Women Working**

572.4 **Group.** \$200,000 in fiscal year 2016 from the
572.5 general fund is for the working group on
572.6 violence against Asian women and children.

572.7 **MERC Program.** \$1,000,000 in fiscal year
572.8 2016 and \$1,000,000 in fiscal year 2017 are
572.9 from the general fund for the MERC program
572.10 under Minnesota Statutes, section 62J.692,
572.11 subdivision 4.

572.12 **Poison Information Center Grants.**

572.13 \$750,000 in fiscal year 2016 and \$750,000 in
572.14 fiscal year 2017 are from the general fund for
572.15 regional poison information center grants
572.16 under Minnesota Statutes, section 145.93.

572.17 **Advanced Care Planning.** \$250,000 in fiscal
572.18 year 2016 is from the general fund to award
572.19 a grant to a statewide advance care planning
572.20 resource organization that has expertise in
572.21 convening and coordinating community-based
572.22 strategies to encourage individuals, families,
572.23 caregivers, and health care providers to begin
572.24 conversations regarding end-of-life care
572.25 choices that express an individual's health care
572.26 values and preferences and are based on
572.27 informed health care decisions. This is a
572.28 onetime appropriation.

572.29 **Early Dental Prevention Initiatives.**

572.30 \$172,000 in fiscal year 2016 and \$140,000 in
572.31 fiscal year 2017 are for the development and
572.32 distribution of the early dental prevention
572.33 initiative under Minnesota Statutes, section
572.34 144.3875.

573.1 **International Medical Graduate Assistance**

573.2 **Program.** (a) \$500,000 in fiscal year 2016
573.3 and \$500,000 in fiscal year 2017 are from the
573.4 health care access fund for the grant programs
573.5 and necessary contracts under Minnesota
573.6 Statutes, section 144.1911, subdivisions 3,
573.7 paragraph (a), clause (4), and 4 and 5. The
573.8 commissioner may use up to \$133,000 per
573.9 year of the appropriation for international
573.10 medical graduate assistance program
573.11 administration duties in Minnesota Statutes,
573.12 section 144.1911, subdivisions 3, 9, and 10,
573.13 and for administering the grant programs
573.14 under Minnesota Statutes, section 144.1911,
573.15 subdivisions 4, 5, and 6. The commissioner
573.16 shall develop recommendations for any
573.17 additional funding required for initiatives
573.18 needed to achieve the objectives of Minnesota
573.19 Statutes, section 144.1911. The commissioner
573.20 shall report the funding recommendations to
573.21 the legislature by January 15, 2016, in the
573.22 report required under Minnesota Statutes,
573.23 section 144.1911, subdivision 10. The base
573.24 for this purpose is \$1,000,000 in fiscal years
573.25 2018 and 2019.

573.26 (b) \$500,000 in fiscal year 2016 and \$500,000
573.27 in fiscal year 2017 are from the health care
573.28 access fund for transfer to the revolving
573.29 international medical graduate residency
573.30 account established in Minnesota Statutes,
573.31 section 144.1911, subdivision 6. This is a
573.32 onetime appropriation.

573.33 **Federally Qualified Health Centers.**

573.34 \$1,000,000 in fiscal year 2016 and \$1,000,000
573.35 in fiscal year 2017 are from the general fund

574.1 to provide subsidies to federally qualified
574.2 health centers under Minnesota Statutes,
574.3 section 145.9269. This is a onetime
574.4 appropriation.

574.5 **Organ Donation.** \$200,000 in fiscal year 2016
574.6 is from the general fund to establish a grant
574.7 program to develop and create culturally
574.8 appropriate outreach programs that provide
574.9 education about the importance of organ
574.10 donation. Grants shall be awarded to a
574.11 federally designated organ procurement
574.12 organization and hospital system that performs
574.13 transplants. This is a onetime appropriation.

574.14 **Primary Care Residency.** \$1,500,000 in
574.15 fiscal year 2016 and \$1,500,000 in fiscal year
574.16 2017 are from the general fund for the
574.17 purposes of the primary care residency
574.18 expansion grant program under Minnesota
574.19 Statutes, section 144.1506.

574.20 ~~**Somali Women's Health Pilot Autism**~~
574.21 ~~**Program.** (a) The commissioner of health~~
574.22 ~~shall establish a pilot program between one or~~
574.23 ~~more federally qualified health centers, as~~
574.24 ~~defined under Minnesota Statutes, section~~
574.25 ~~145.9269, a nonprofit organization that helps~~
574.26 ~~Somali women, and the Minnesota Evaluation~~
574.27 ~~Studies Institute, to develop a promising~~
574.28 ~~strategy to address the preventative and~~
574.29 ~~primary health care needs of, and address~~
574.30 ~~health inequities experienced by, first~~
574.31 ~~generation Somali women. The pilot program~~
574.32 ~~must collaboratively develop a patient flow~~
574.33 ~~process for first generation Somali women by:~~
574.34 ~~(1) addressing and identifying clinical and~~
574.35 ~~cultural barriers to Somali women accessing~~

575.1 ~~preventative and primary care, including, but~~
575.2 ~~not limited to, cervical and breast cancer~~
575.3 ~~screenings;~~

575.4 ~~(2) developing a culturally appropriate health~~
575.5 ~~curriculum for Somali women based on the~~
575.6 ~~outcomes from the community-based~~
575.7 ~~participatory research report "Cultural~~
575.8 ~~Traditions and the Reproductive Health of~~
575.9 ~~Somali Refugees and Immigrants" to increase~~
575.10 ~~the health literacy of Somali women and~~
575.11 ~~develop culturally specific health care~~
575.12 ~~information; and~~

575.13 ~~(3) training the federally qualified health~~
575.14 ~~center's providers and staff to enhance~~
575.15 ~~provider and staff cultural competence~~
575.16 ~~regarding the cultural barriers, including~~
575.17 ~~female genital cutting.~~

575.18 ~~(b) The pilot program must develop a process~~
575.19 ~~that results in increased screening rates for~~
575.20 ~~cervical and breast cancer and can be~~
575.21 ~~replicated by other providers serving ethnic~~
575.22 ~~minorities. The pilot program must conduct~~
575.23 ~~an evaluation of the new patient flow process~~
575.24 ~~used by Somali women to access federally~~
575.25 ~~qualified health centers services award a grant~~
575.26 ~~to Dakota County to partner with a~~
575.27 ~~community-based organization with expertise~~
575.28 ~~in serving Somali children with autism. The~~
575.29 ~~grant must address barriers to accessing health~~
575.30 ~~care and other resources by providing outreach~~
575.31 ~~to Somali families on available support and~~
575.32 ~~training to providers on Somali culture.~~

575.33 ~~(c) The pilot program must report the~~
575.34 ~~outcomes to the commissioner by June 30,~~
575.35 ~~2017. The grantee shall report to the~~

576.1 commissioner and the chairs and ranking
576.2 minority members of the legislative
576.3 committees with jurisdiction over health care
576.4 policy and finance on the grant funds used and
576.5 any notable outcomes achieved by January 15,
576.6 2019.

576.7 (d) \$110,000 in fiscal year 2016 is for the
576.8 ~~Somali women's health pilot program grant to~~
576.9 Dakota County. Of this appropriation, the
576.10 commissioner may use up to \$10,000 to
576.11 administer the ~~program grant to Dakota~~
576.12 County. This appropriation is available until
576.13 June 30, 2017. This is a onetime appropriation.

576.14 **Menthol Cigarette Usage in**
576.15 **African-American Community Intervention**
576.16 **Grants.** Of the health care access fund
576.17 appropriation for the statewide health
576.18 improvement program, \$200,000 in fiscal year
576.19 2016 is for at least one grant that must be
576.20 awarded by the commissioner to implement
576.21 strategies and interventions to reduce the
576.22 disproportionately high usage of cigarettes by
576.23 African-Americans, especially the use of
576.24 menthol-flavored cigarettes, as well as the
576.25 disproportionate harm tobacco causes in that
576.26 community. The grantee shall engage
576.27 members of the African-American community
576.28 and community-based organizations. This
576.29 grant shall be awarded as part of the statewide
576.30 health improvement program grants awarded
576.31 on November 1, 2015, and must meet the
576.32 requirements of Minnesota Statutes, section
576.33 145.986.

576.34 **Targeted Home Visiting System.** (a) \$75,000
576.35 in fiscal year 2016 is for the commissioner of

577.1 health, in consultation with the commissioners
577.2 of human services and education, community
577.3 health boards, tribal nations, and other home
577.4 visiting stakeholders, to design baseline
577.5 training for new home visitors to ensure
577.6 statewide coordination across home visiting
577.7 programs.

577.8 (b) \$575,000 in fiscal year 2016 and
577.9 \$2,000,000 fiscal year 2017 are to provide
577.10 grants to community health boards and tribal
577.11 nations for start-up grants for new
577.12 nurse-family partnership programs and for
577.13 grants to expand existing programs to serve
577.14 first-time mothers, prenatally by 28 weeks
577.15 gestation until the child is two years of age,
577.16 who are eligible for medical assistance under
577.17 Minnesota Statutes, chapter 256B, or the
577.18 federal Special Supplemental Nutrition
577.19 Program for Women, Infants, and Children.

577.20 The commissioner shall award grants to
577.21 community health boards or tribal nations in
577.22 metropolitan and rural areas of the state.

577.23 Priority for all grants shall be given to
577.24 nurse-family partnership programs that
577.25 provide services through a Minnesota health
577.26 care program-enrolled provider that accepts
577.27 medical assistance. Additionally, priority for
577.28 grants to rural areas shall be given to
577.29 community health boards and tribal nations
577.30 that expand services within regional
577.31 partnerships that provide the nurse-family
577.32 partnership program. Funding available under
577.33 this paragraph may only be used to
577.34 supplement, not to replace, funds being used
577.35 for nurse-family partnership home visiting
577.36 services as of June 30, 2015.

578.1 **Opiate Antagonists.** \$270,000 in fiscal year
578.2 2016 and \$20,000 in fiscal year 2017 are from
578.3 the general fund for grants to the eight regional
578.4 emergency medical services programs to
578.5 purchase opiate antagonists and educate and
578.6 train emergency medical services persons, as
578.7 defined in Minnesota Statutes, section
578.8 144.7401, subdivision 4, clauses (1) and (2),
578.9 in the use of these antagonists in the event of
578.10 an opioid or heroin overdose. For the purposes
578.11 of this paragraph, "opiate antagonist" means
578.12 naloxone hydrochloride or any similarly acting
578.13 drug approved by the federal Food and Drug
578.14 Administration for the treatment of drug
578.15 overdose. Grants under this paragraph must
578.16 be distributed to all eight regional emergency
578.17 medical services programs. This is a onetime
578.18 appropriation and is available until June 30,
578.19 2017. The commissioner may use up to
578.20 \$20,000 of the amount for opiate antagonists
578.21 for administration.

578.22 **Local and Tribal Public Health Grants.** (a)
578.23 \$894,000 in fiscal year 2016 and \$894,000 in
578.24 fiscal year 2017 are for an increase in local
578.25 public health grants for community health
578.26 boards under Minnesota Statutes, section
578.27 145A.131, subdivision 1, paragraph (e).

578.28 (b) \$106,000 in fiscal year 2016 and \$106,000
578.29 in fiscal year 2017 are for an increase in
578.30 special grants to tribal governments under
578.31 Minnesota Statutes, section 145A.14,
578.32 subdivision 2a.

578.33 **HCBS Employee Scholarships.** \$1,000,000
578.34 in fiscal year 2016 and \$1,000,000 in fiscal
578.35 year 2017 are from the general fund for the

579.1 home and community-based services
579.2 employee scholarship program under
579.3 Minnesota Statutes, section 144.1503. The
579.4 commissioner may use up to \$50,000 of the
579.5 amount for the HCBS employee scholarships
579.6 for administration.

579.7 **Family Planning Special Projects.**
579.8 \$1,000,000 in fiscal year 2016 and \$1,000,000
579.9 in fiscal year 2017 are from the general fund
579.10 for family planning special project grants
579.11 under Minnesota Statutes, section 145.925.

579.12 **Positive Alternatives.** \$1,000,000 in fiscal
579.13 year 2016 and \$1,000,000 in fiscal year 2017
579.14 are from the general fund for positive abortion
579.15 alternatives under Minnesota Statutes, section
579.16 145.4235.

579.17 **Safe Harbor for Sexually Exploited Youth.**
579.18 \$700,000 in fiscal year 2016 and \$700,000 in
579.19 fiscal year 2017 are from the general fund for
579.20 the safe harbor program under Minnesota
579.21 Statutes, sections 145.4716 to 145.4718. Funds
579.22 shall be used for grants to increase the number
579.23 of regional navigators; training for
579.24 professionals who engage with exploited or
579.25 at-risk youth; implementing statewide
579.26 protocols and best practices for effectively
579.27 identifying, interacting with, and referring
579.28 sexually exploited youth to appropriate
579.29 resources; and program operating costs.

579.30 **Health Care Grants for Uninsured**
579.31 **Individuals.** (a) \$62,500 in fiscal year 2016
579.32 and \$62,500 in fiscal year 2017 are from the
579.33 health care access fund for dental provider
579.34 grants in Minnesota Statutes, section 145.929,
579.35 subdivision 1.

580.1 (b) \$218,750 in fiscal year 2016 and \$218,750
580.2 in fiscal year 2017 are from the health care
580.3 access fund for community mental health
580.4 program grants in Minnesota Statutes, section
580.5 145.929, subdivision 2.

580.6 (c) \$750,000 in fiscal year 2016 and \$750,000
580.7 in fiscal year 2017 are from the health care
580.8 access fund for the emergency medical
580.9 assistance outlier grant program in Minnesota
580.10 Statutes, section 145.929, subdivision 3.

580.11 (d) \$218,750 of the health care access fund
580.12 appropriation in fiscal year 2016 and \$218,750
580.13 in fiscal year 2017 are for community health
580.14 center grants under Minnesota Statutes, section
580.15 145.9269. A community health center that
580.16 receives a grant from this appropriation is not
580.17 eligible for a grant under paragraph (b).

580.18 (e) The commissioner may use up to \$25,000
580.19 of the appropriations for health care grants for
580.20 uninsured individuals in fiscal years 2016 and
580.21 2017 for grant administration.

580.22 **TANF Appropriations.** (a) \$1,156,000 of the
580.23 TANF funds is appropriated each year of the
580.24 biennium to the commissioner for family
580.25 planning grants under Minnesota Statutes,
580.26 section 145.925.

580.27 (b) \$3,579,000 of the TANF funds is
580.28 appropriated each year of the biennium to the
580.29 commissioner for home visiting and nutritional
580.30 services listed under Minnesota Statutes,
580.31 section 145.882, subdivision 7, clauses (6) and
580.32 (7). Funds must be distributed to community
580.33 health boards according to Minnesota Statutes,
580.34 section 145A.131, subdivision 1.

581.1 (c) \$2,000,000 of the TANF funds is
581.2 appropriated each year of the biennium to the
581.3 commissioner for decreasing racial and ethnic
581.4 disparities in infant mortality rates under
581.5 Minnesota Statutes, section 145.928,
581.6 subdivision 7.

581.7 (d) \$4,978,000 of the TANF funds is
581.8 appropriated each year of the biennium to the
581.9 commissioner for the family home visiting
581.10 grant program according to Minnesota
581.11 Statutes, section 145A.17. \$4,000,000 of the
581.12 funding must be distributed to community
581.13 health boards according to Minnesota Statutes,
581.14 section 145A.131, subdivision 1. \$978,000 of
581.15 the funding must be distributed to tribal
581.16 governments as provided in Minnesota
581.17 Statutes, section 145A.14, subdivision 2a.

581.18 (e) The commissioner may use up to 6.23
581.19 percent of the funds appropriated each fiscal
581.20 year to conduct the ongoing evaluations
581.21 required under Minnesota Statutes, section
581.22 145A.17, subdivision 7, and training and
581.23 technical assistance as required under
581.24 Minnesota Statutes, section 145A.17,
581.25 subdivisions 4 and 5.

581.26 **TANF Carryforward.** Any unexpended
581.27 balance of the TANF appropriation in the first
581.28 year of the biennium does not cancel but is
581.29 available for the second year.

581.30 **Health Professional Loan Forgiveness.**
581.31 \$2,631,000 in fiscal year 2016 and \$2,631,000
581.32 in fiscal year 2017 are from the health care
581.33 access fund for the purposes of Minnesota
581.34 Statutes, section 144.1501. Of this
581.35 appropriation, the commissioner may use up

582.1 to \$131,000 each year to administer the
582.2 program.

582.3 **Minnesota Stroke System.** \$350,000 in fiscal
582.4 year 2016 and \$350,000 in fiscal year 2017
582.5 are from the general fund for the Minnesota
582.6 stroke system.

582.7 **Prevention of Violence in Health Care.**
582.8 \$50,000 in fiscal year 2016 is to continue the
582.9 prevention of violence in health care program
582.10 and creating violence prevention resources for
582.11 hospitals and other health care providers to
582.12 use in training their staff on violence
582.13 prevention. This is a onetime appropriation
582.14 and is available until June 30, 2017.

582.15 **Health Care Savings Determinations.** (a)
582.16 The health care access fund base for the state
582.17 health improvement program is decreased by
582.18 \$261,000 in fiscal year 2016 and decreased
582.19 by \$110,000 in fiscal year 2017.

582.20 (b) \$261,000 in fiscal year 2016 and \$110,000
582.21 in fiscal year 2017 are from the health care
582.22 access fund for the forecasting, cost reporting,
582.23 and analysis required by Minnesota Statutes,
582.24 section 62U.10, subdivisions 6 and 7.

582.25 **Base Level Adjustments.** The general fund
582.26 base is decreased by \$1,070,000 in fiscal year
582.27 2018 and by \$1,020,000 in fiscal year 2019.
582.28 The state government special revenue fund
582.29 base is increased by \$33,000 in fiscal year
582.30 2018. The health care access fund base is
582.31 increased by \$610,000 in fiscal year 2018 and
582.32 by \$23,000 in fiscal year 2019.

583.1 Sec. 14. **TRANSFERS.**

583.2 Subdivision 1. Grants. The commissioner of human services, with the approval of the
583.3 commissioner of management and budget, may transfer unencumbered appropriation balances
583.4 for the biennium ending June 30, 2019, within fiscal years among the MFIP, general
583.5 assistance, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota
583.6 Statutes, section 119B.05, Minnesota supplemental aid, and group residential housing
583.7 programs, the entitlement portion of Northstar Care for Children under Minnesota Statutes,
583.8 chapter 256N, and the entitlement portion of the chemical dependency consolidated treatment
583.9 fund, and between fiscal years of the biennium. The commissioner shall inform the chairs
583.10 and ranking minority members of the senate Health and Human Services Finance and Policy
583.11 Committee, the senate Human Services Reform Finance and Policy Committee, and the
583.12 house of representatives Health and Human Services Finance Committee quarterly about
583.13 transfers made under this subdivision.

583.14 Subd. 2. Administration. Positions, salary money, and nonsalary administrative money
583.15 may be transferred within the Departments of Health and Human Services as the
583.16 commissioners consider necessary, with the advance approval of the commissioner of
583.17 management and budget. The commissioner shall inform the chairs and ranking minority
583.18 members of the senate Health and Human Services Finance and Policy Committee, the
583.19 senate Human Services Reform Finance and Policy Committee, and the house of
583.20 representatives Health and Human Services Finance Committee quarterly about transfers
583.21 made under this subdivision.

583.22 Sec. 15. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

583.23 The commissioners of health and human services shall not use indirect cost allocations
583.24 to pay for the operational costs of any program for which they are responsible.

583.25 Sec. 16. **EXPIRATION OF UNCODIFIED LANGUAGE.**

583.26 All uncodified language contained in this article expires on June 30, 2019, unless a
583.27 different expiration date is explicit.

583.28 Sec. 17. **EFFECTIVE DATE.**

583.29 This article is effective July 1, 2017, unless a different effective date is specified.

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Article locations in S0800-4

ARTICLE 1	COMMUNITY SUPPORTS	Page.Ln 3.5
ARTICLE 2	HOUSING	Page.Ln 63.16
ARTICLE 3	CONTINUING CARE	Page.Ln 112.29
ARTICLE 4	HEALTH CARE	Page.Ln 163.13
ARTICLE 5	HEALTH INSURANCE	Page.Ln 235.26
ARTICLE 6	DIRECT CARE AND TREATMENT	Page.Ln 244.11
ARTICLE 7	CHILDREN AND FAMILIES	Page.Ln 246.7
ARTICLE 8	CHEMICAL AND MENTAL HEALTH SERVICES	Page.Ln 268.1
ARTICLE 9	OPERATIONS	Page.Ln 349.28
ARTICLE 10	HEALTH DEPARTMENT	Page.Ln 358.18
ARTICLE 11	HEALTH LICENSING BOARDS	Page.Ln 431.26
ARTICLE 12	OPIATE ABUSE PREVENTION	Page.Ln 476.12
ARTICLE 13	MISCELLANEOUS	Page.Ln 482.12
ARTICLE 14	NURSING FACILITY TECHNICAL CORRECTIONS	Page.Ln 487.19
ARTICLE 15	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 514.1
ARTICLE 16	APPROPRIATIONS	Page.Ln 515.13

13.468 DATA SHARING WITHIN COUNTIES.

County welfare, human services, corrections, public health, and veterans service units within a county may inform each other as to whether an individual or family currently is being served by the county unit, without the consent of the subject of the data. Data that may be shared are limited to the following: the name, telephone number, and last known address of the data subject; and the identification and contact information regarding personnel of the county unit responsible for working with the individual or family. If further information is necessary for the county unit to carry out its duties, each county unit may share additional data if the unit is authorized by state statute or federal law to do so or the individual gives written, informed consent.

62V.01 TITLE.

This chapter may be cited as the "MNSure Act."

62V.02 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of this chapter, the following terms have the meanings given.

Subd. 2. **Board.** "Board" means the Board of Directors of MNSure specified in section 62V.04.

Subd. 3. **Dental plan.** "Dental plan" has the meaning defined in section 62Q.76, subdivision 3.

Subd. 4. **Health plan.** "Health plan" means a policy, contract, certificate, or agreement defined in section 62A.011, subdivision 3.

Subd. 5. **Health carrier.** "Health carrier" has the meaning defined in section 62A.011.

Subd. 6. **Individual market.** "Individual market" means the market for health insurance coverage offered to individuals.

Subd. 7. **Insurance producer.** "Insurance producer" has the meaning defined in section 60K.31.

Subd. 8. **MNSure.** "MNSure" means the state health benefit exchange as described in section 1311 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

Subd. 9. **Navigator.** "Navigator" has the meaning described in section 1311(i) of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

Subd. 10. **Public health care program.** "Public health care program" means any public health care program administered by the commissioner of human services.

Subd. 11. **Qualified health plan.** "Qualified health plan" means a health plan that meets the definition in section 1301(a) of the Affordable Care Act, Public Law 111-148, and has been certified by the board in accordance with section 62V.05, subdivision 5, to be offered through MNSure.

Subd. 12. **Small group market.** "Small group market" means the market for health insurance coverage offered to small employers as defined in section 62L.02, subdivision 26.

Subd. 13. **Web site.** "Web site" means a site maintained on the World Wide Web by MNSure that allows for access to information and services provided by MNSure.

62V.03 MNSURE; ESTABLISHMENT.

Subdivision 1. **Creation.** MNSure is created as a board under section 15.012, paragraph (a), to:

(1) promote informed consumer choice, innovation, competition, quality, value, market participation, affordability, suitable and meaningful choices, health improvement, care management, reduction of health disparities, and portability of health plans;

(2) facilitate and simplify the comparison, choice, enrollment, and purchase of health plans for individuals purchasing in the individual market through MNSure and for employees and employers purchasing in the small group market through MNSure;

(3) assist small employers with access to small business health insurance tax credits and to assist individuals with access to public health care programs, premium assistance tax credits and cost-sharing reductions, and certificates of exemption from individual responsibility requirements;

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(4) facilitate the integration and transition of individuals between public health care programs and health plans in the individual or group market and develop processes that, to the maximum extent possible, provide for continuous coverage; and

(5) establish and modify as necessary a name and brand for MNsure based on market studies that show maximum effectiveness in attracting the uninsured and motivating them to take action.

Subd. 2. Application of other law. (a) MNsure must be reviewed by the legislative auditor under section 3.971. The legislative auditor shall audit the books, accounts, and affairs of MNsure once each year or less frequently as the legislative auditor's funds and personnel permit. Upon the audit of the financial accounts and affairs of MNsure, MNsure is liable to the state for the total cost and expenses of the audit, including the salaries paid to the examiners while actually engaged in making the examination. The legislative auditor may bill MNsure either monthly or at the completion of the audit. All collections received for the audits must be deposited in the general fund and are appropriated to the legislative auditor. Pursuant to section 3.97, subdivision 3a, the Legislative Audit Commission is requested to direct the legislative auditor to report by March 1, 2014, to the legislature on any duplication of services that occurs within state government as a result of the creation of MNsure. The legislative auditor may make recommendations on consolidating or eliminating any services deemed duplicative. The board shall reimburse the legislative auditor for any costs incurred in the creation of this report.

(b) Board members of MNsure are subject to sections 10A.07 and 10A.09. Board members and the personnel of MNsure are subject to section 10A.071.

(c) All meetings of the board and of the Minnesota Eligibility System Executive Steering Committee established under section 62V.055 shall comply with the open meeting law in chapter 13D.

(d) The board and the Web site are exempt from chapter 60K. Any employee of MNsure who sells, solicits, or negotiates insurance to individuals or small employers must be licensed as an insurance producer under chapter 60K.

(e) Section 3.3005 applies to any federal funds received by MNsure.

(f) A MNsure decision that requires a vote of the board, other than a decision that applies only to hiring of employees or other internal management of MNsure, is an "administrative action" under section 10A.01, subdivision 2.

Subd. 3. Continued operation of a private marketplace. (a) Nothing in this chapter shall be construed to prohibit: (1) a health carrier from offering outside of MNsure a health plan to a qualified individual or qualified employer; and (2) a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of MNsure.

(b) Nothing in this chapter shall be construed to restrict the choice of a qualified individual to enroll or not enroll in a qualified health plan or to participate in MNsure. Nothing in this chapter shall be construed to compel an individual to enroll in a qualified health plan or to participate in MNsure.

(c) For purposes of this subdivision, "qualified individual" and "qualified employer" have the meanings given in section 1312 of the Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act.

62V.04 GOVERNANCE.

Subdivision 1. Board. MNsure is governed by a board of directors with seven members.

Subd. 2. Appointment. (a) Board membership of MNsure consists of the following:

(1) three members appointed by the governor with the advice and consent of both the senate and the house of representatives acting separately in accordance with paragraph (d), with one member representing the interests of individual consumers eligible for individual market coverage, one member representing individual consumers eligible for public health care program coverage, and one member representing small employers. Members are appointed to serve four-year terms following the initial staggered-term lot determination;

(2) three members appointed by the governor with the advice and consent of both the senate and the house of representatives acting separately in accordance with paragraph (d) who have demonstrated expertise, leadership, and innovation in the following areas: one member representing the areas of health administration, health care finance, health plan purchasing, and health care delivery systems; one member representing the areas of public health, health disparities, public health care programs, and the uninsured; and one member representing health policy issues related to the small group and individual markets. Members are appointed to serve four-year terms following the initial staggered-term lot determination; and

(3) the commissioner of human services or a designee.

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(b) Section 15.0597 shall apply to all appointments, except for the commissioner.

(c) The governor shall make appointments to the board that are consistent with federal law and regulations regarding its composition and structure. All board members appointed by the governor must be legal residents of Minnesota.

(d) Upon appointment by the governor, a board member shall exercise duties of office immediately. If both the house of representatives and the senate vote not to confirm an appointment, the appointment terminates on the day following the vote not to confirm in the second body to vote.

(e) Initial appointments shall be made by April 30, 2013.

(f) One of the six members appointed under paragraph (a), clause (1) or (2), must have experience in representing the needs of vulnerable populations and persons with disabilities.

(g) Membership on the board must include representation from outside the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Subd. 3. **Terms.** (a) Board members may serve no more than two consecutive terms, except for the commissioner or the commissioner's designee, who shall serve until replaced by the governor.

(b) A board member may resign at any time by giving written notice to the board.

(c) The appointed members under subdivision 2, paragraph (a), clauses (1) and (2), shall have an initial term of two, three, or four years, determined by lot by the secretary of state.

Subd. 4. **Conflicts of interest.** (a) Within one year prior to or at any time during their appointed term, board members appointed under subdivision 2, paragraph (a), clauses (1) and (2), shall not be employed by, be a member of the board of directors of, or otherwise be a representative of a health carrier, institutional health care provider or other entity providing health care, navigator, insurance producer, or other entity in the business of selling items or services of significant value to or through MNsure. For purposes of this paragraph, "health care provider or entity" does not include an academic institution.

(b) Board members must recuse themselves from discussion of and voting on an official matter if the board member has a conflict of interest. A conflict of interest means an association including a financial or personal association that has the potential to bias or have the appearance of biasing a board member's decisions in matters related to MNsure or the conduct of activities under this chapter.

(c) No board member shall have a spouse who is an executive of a health carrier.

(d) No member of the board may currently serve as a lobbyist, as defined under section 10A.01, subdivision 21.

Subd. 5. **Acting chair; first meeting; supervision.** (a) The governor shall designate as acting chair one of the appointees described in subdivision 2.

(b) The board shall hold its first meeting within 60 days of enactment.

(c) The board shall elect a chair to replace the acting chair at the first meeting.

Subd. 6. **Chair.** The board shall have a chair, elected by a majority of members. The chair shall serve for one year.

Subd. 7. **Officers.** The members of the board shall elect officers by a majority of members. The officers shall serve for one year.

Subd. 8. **Vacancies.** If a vacancy occurs, the governor shall appoint a new member within 90 days, and the newly appointed member shall be subject to the same confirmation process described in subdivision 2.

Subd. 9. **Removal.** (a) A board member may be removed by the appointing authority and a majority vote of the board following notice and hearing before the board. For purposes of this subdivision, the appointing authority or a designee of the appointing authority shall be a voting member of the board for purposes of constituting a quorum.

(b) A conflict of interest as defined in subdivision 4, shall be cause for removal from the board.

Subd. 10. **Meetings.** The board shall meet at least quarterly.

Subd. 11. **Quorum.** A majority of the members of the board constitutes a quorum, and the affirmative vote of a majority of members of the board is necessary and sufficient for action taken by the board.

Subd. 12. **Compensation.** (a) The board members shall be paid a salary not to exceed the salary limits established under section 15A.0815, subdivision 4. The salary for board members shall be set in accordance with this subdivision and section 15A.0815, subdivision 5. This paragraph expires December 31, 2015.

(b) Beginning January 1, 2016, the board members may be compensated in accordance with section 15.0575.

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Subd. 13. **Advisory committees.** (a) The board shall establish and maintain advisory committees to provide insurance producers, health care providers, the health care industry, consumers, and other stakeholders with the opportunity to advise the board regarding the operation of MNsure as required under section 1311(d)(6) of the Affordable Care Act, Public Law 111-148. The board shall regularly consult with the advisory committees. The advisory committees established under this paragraph shall not expire.

(b) The board may establish additional advisory committees, as necessary, to gather and provide information to the board in order to facilitate the operation of MNsure. The advisory committees established under this paragraph shall not expire, except by action of the board.

(c) Section 15.0597 shall not apply to any advisory committee established by the board under this subdivision.

(d) The board may provide compensation and expense reimbursement under section 15.059, subdivision 3, to members of the advisory committees.

62V.05 RESPONSIBILITIES AND POWERS OF MNSURE.

Subdivision 1. **General.** (a) The board shall operate MNsure according to this chapter and applicable state and federal law.

(b) The board has the power to:

(1) employ personnel and delegate administrative, operational, and other responsibilities to the director and other personnel as deemed appropriate by the board. This authority is subject to chapters 43A and 179A. The director and managerial staff of MNsure shall serve in the unclassified service and shall be governed by a compensation plan prepared by the board, submitted to the commissioner of management and budget for review and comment within 14 days of its receipt, and approved by the Legislative Coordinating Commission and the legislature under section 3.855, except that section 15A.0815, subdivision 5, paragraph (e), shall not apply;

(2) establish the budget of MNsure;

(3) seek and accept money, grants, loans, donations, materials, services, or advertising revenue from government agencies, philanthropic organizations, and public and private sources to fund the operation of MNsure. No health carrier or insurance producer shall advertise on MNsure;

(4) contract for the receipt and provision of goods and services;

(5) enter into information-sharing agreements with federal and state agencies and other entities, provided the agreements include adequate protections with respect to the confidentiality and integrity of the information to be shared, and comply with all applicable state and federal laws, regulations, and rules, including the requirements of section 62V.06; and

(6) exercise all powers reasonably necessary to implement and administer the requirements of this chapter and the Affordable Care Act, Public Law 111-148.

(c) The board shall establish policies and procedures to gather public comment and provide public notice in the State Register.

(d) Within 180 days of enactment, the board shall establish bylaws, policies, and procedures governing the operations of MNsure in accordance with this chapter.

Subd. 2. **Operations funding.** (a) Prior to January 1, 2015, MNsure shall retain or collect up to 1.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the cash reserves of MNsure, but the amount collected shall not exceed a dollar amount equal to 25 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(b) Beginning January 1, 2015, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected shall not exceed a dollar amount equal to 50 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(c) Beginning January 1, 2016, MNsure shall retain or collect up to 3.5 percent of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund the operations of MNsure, but the amount collected may never exceed a dollar amount greater than 100 percent of the funds collected under section 62E.11, subdivision 6, for calendar year 2012.

(d) For fiscal years 2014 and 2015, the commissioner of management and budget is authorized to provide cash flow assistance of up to \$20,000,000 from the special revenue fund or the statutory general fund under section 16A.671, subdivision 3, paragraph (a), to MNsure. Any funds provided under this paragraph shall be repaid, with interest, by June 30, 2015.

(e) Funding for the operations of MNsure shall cover any compensation provided to navigators participating in the navigator program.

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Subd. 3. **Insurance producers.** (a) By April 30, 2013, the board, in consultation with the commissioner of commerce, shall establish certification requirements that must be met by insurance producers in order to assist individuals and small employers with purchasing coverage through MNsure. Prior to January 1, 2015, the board may amend the requirements, only if necessary, due to a change in federal rules.

(b) Certification requirements shall not exceed the requirements established under Code of Federal Regulations, title 45, part 155.220. Certification shall include training on health plans available through MNsure, available tax credits and cost-sharing arrangements, compliance with privacy and security standards, eligibility verification processes, online enrollment tools, and basic information on available public health care programs. Training required for certification under this subdivision shall qualify for continuing education requirements for insurance producers required under chapter 60K, and must comply with course approval requirements under chapter 45.

(c) Producer compensation shall be established by health carriers that provide health plans through MNsure. The structure of compensation to insurance producers must be similar for health plans sold through MNsure and outside MNsure.

(d) Any insurance producer compensation structure established by a health carrier for the small group market must include compensation for defined contribution plans that involve multiple health carriers. The compensation offered must be commensurate with other small group market defined health plans.

(e) Any insurance producer assisting an individual or small employer with purchasing coverage through MNsure must disclose, orally and in writing, to the individual or small employer at the time of the first solicitation with the prospective purchaser the following:

(1) the health carriers and qualified health plans offered through MNsure that the producer is authorized to sell, and that the producer may not be authorized to sell all the qualified health plans offered through MNsure;

(2) that the producer may be receiving compensation from a health carrier for enrolling the individual or small employer into a particular health plan; and

(3) that information on all qualified health plans offered through MNsure is available through the MNsure Web site.

For purposes of this paragraph, "solicitation" means any contact by a producer, or any person acting on behalf of a producer made for the purpose of selling or attempting to sell coverage through MNsure. If the first solicitation is made by telephone, the disclosures required under this paragraph need not be made in writing, but the fact that disclosure has been made must be acknowledged on the application.

(f) Beginning January 15, 2015, each health carrier that offers or sells qualified health plans through MNsure shall report in writing to the board and the commissioner of commerce the compensation and other incentives it offers or provides to insurance producers with regard to each type of health plan the health carrier offers or sells both inside and outside of MNsure. Each health carrier shall submit a report annually and upon any change to the compensation or other incentives offered or provided to insurance producers.

(g) Nothing in this chapter shall prohibit an insurance producer from offering professional advice and recommendations to a small group purchaser based upon information provided to the producer.

(h) An insurance producer that offers health plans in the small group market shall notify each small group purchaser of which group health plans qualify for Internal Revenue Service approved section 125 tax benefits. The insurance producer shall also notify small group purchasers of state law provisions that benefit small group plans when the employer agrees to pay 50 percent or more of its employees' premium. Individuals who are eligible for cost-effective medical assistance will count toward the 75 percent participation requirement in section 62L.03, subdivision 3.

(i) Nothing in this subdivision shall be construed to limit the licensure requirements or regulatory functions of the commissioner of commerce under chapter 60K.

Subd. 4. **Navigator; in-person assister; call center.** (a) The board shall establish policies and procedures for the ongoing operation of a navigator program, in-person assister program, call center, and customer service provisions for MNsure to be implemented beginning January 1, 2015.

(b) Until the implementation of the policies and procedures described in paragraph (a), the following shall be in effect:

(1) the navigator program shall be met by section 256.962;

(2) entities eligible to be navigators, including entities defined in Code of Federal Regulations, title 45, part 155.210 (c)(2), may serve as in-person assisters;

(3) the board shall establish requirements and compensation for the navigator program and the in-person assister program by April 30, 2013. Compensation for navigators and in-person

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assisters must take into account any other compensation received by the navigator or in-person assister for conducting the same or similar services; and

(4) call center operations shall utilize existing state resources and personnel, including referrals to counties for medical assistance.

(c) The board shall establish a toll-free number for MNsure and may hire and contract for additional resources as deemed necessary.

(d) The navigator program and in-person assister program must meet the requirements of section 1311(i) of the Affordable Care Act, Public Law 111-148. In establishing training standards for the navigators and in-person assisters, the board must ensure that all entities and individuals carrying out navigator and in-person assister functions have training in the needs of underserved and vulnerable populations; eligibility and enrollment rules and procedures; the range of available public health care programs and qualified health plan options offered through MNsure; and privacy and security standards. For calendar year 2014, the commissioner of human services shall ensure that the navigator program under section 256.962 provides application assistance for both qualified health plans offered through MNsure and public health care programs.

(e) The board must ensure that any information provided by navigators, in-person assisters, the call center, or other customer assistance portals be accessible to persons with disabilities and that information provided on public health care programs include information on other coverage options available to persons with disabilities.

Subd. 5. Health carrier and health plan requirements; participation. (a) Beginning January 1, 2015, the board may establish certification requirements for health carriers and health plans to be offered through MNsure that satisfy federal requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

(b) Paragraph (a) does not apply if by June 1, 2013, the legislature enacts regulatory requirements that:

- (1) apply uniformly to all health carriers and health plans in the individual market;
- (2) apply uniformly to all health carriers and health plans in the small group market; and
- (3) satisfy minimum federal certification requirements under section 1311(c)(1) of the

Affordable Care Act, Public Law 111-148.

(c) In accordance with section 1311(e) of the Affordable Care Act, Public Law 111-148, the board shall establish policies and procedures for certification and selection of health plans to be offered as qualified health plans through MNsure. The board shall certify and select a health plan as a qualified health plan to be offered through MNsure, if:

(1) the health plan meets the minimum certification requirements established in paragraph (a) or the market regulatory requirements in paragraph (b);

(2) the board determines that making the health plan available through MNsure is in the interest of qualified individuals and qualified employers;

(3) the health carrier applying to offer the health plan through MNsure also applies to offer health plans at each actuarial value level and service area that the health carrier currently offers in the individual and small group markets; and

(4) the health carrier does not apply to offer health plans in the individual and small group markets through MNsure under a separate license of a parent organization or holding company under section 60D.15, that is different from what the health carrier offers in the individual and small group markets outside MNsure.

(d) In determining the interests of qualified individuals and employers under paragraph (c), clause (2), the board may not exclude a health plan for any reason specified under section 1311(e)(1)(B) of the Affordable Care Act, Public Law 111-148. The board may consider:

(1) affordability;

(2) quality and value of health plans;

(3) promotion of prevention and wellness;

(4) promotion of initiatives to reduce health disparities;

(5) market stability and adverse selection;

(6) meaningful choices and access;

(7) alignment and coordination with state agency and private sector purchasing strategies and payment reform efforts; and

(8) other criteria that the board determines appropriate.

(e) For qualified health plans offered through MNsure on or after January 1, 2015, the board shall establish policies and procedures under paragraphs (c) and (d) for selection of health plans to be offered as qualified health plans through MNsure by February 1 of each year, beginning February 1, 2014. The board shall consistently and uniformly apply all policies and procedures and any requirements, standards, or criteria to all health carriers and health plans. For

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any policies, procedures, requirements, standards, or criteria that are defined as rules under section 14.02, subdivision 4, the board may use the process described in subdivision 9.

(f) For 2014, the board shall not have the power to select health carriers and health plans for participation in MNsure. The board shall permit all health plans that meet the certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, to be offered through MNsure.

(g) Under this subdivision, the board shall have the power to verify that health carriers and health plans are properly certified to be eligible for participation in MNsure.

(h) The board has the authority to decertify health carriers and health plans that fail to maintain compliance with section 1311(c)(1) of the Affordable Care Act, Public Law 111-148.

(i) For qualified health plans offered through MNsure beginning January 1, 2015, health carriers must use the most current addendum for Indian health care providers approved by the Centers for Medicare and Medicaid Services and the tribes as part of their contracts with Indian health care providers. MNsure shall comply with all future changes in federal law with regard to health coverage for the tribes.

Subd. 6. Appeals. (a) The board may conduct hearings, appoint hearing officers, and recommend final orders related to appeals of any MNsure determinations, except for those determinations identified in paragraph (d). An appeal by a health carrier regarding a specific certification or selection determination made by MNsure under subdivision 5 must be conducted as a contested case proceeding under chapter 14, with the report or order of the administrative law judge constituting the final decision in the case, subject to judicial review under sections 14.63 to 14.69. For other appeals, the board shall establish hearing processes which provide for a reasonable opportunity to be heard and timely resolution of the appeal and which are consistent with the requirements of federal law and guidance. An appealing party may be represented by legal counsel at these hearings, but this is not a requirement.

(b) MNsure may establish service-level agreements with state agencies to conduct hearings for appeals. Notwithstanding section 471.59, subdivision 1, a state agency is authorized to enter into service-level agreements for this purpose with MNsure.

(c) For proceedings under this subdivision, MNsure may be represented by an attorney who is an employee of MNsure.

(d) This subdivision does not apply to appeals of determinations where a state agency hearing is available under section 256.045.

(e) An appellant aggrieved by an order of MNsure issued in an eligibility appeal, as defined in Minnesota Rules, part 7700.0101, may appeal the order to the district court of the appellant's county of residence by serving a written copy of a notice of appeal upon MNsure and any other adverse party of record within 30 days after the date MNsure issued the order, the amended order, or order affirming the original order, and by filing the original notice and proof of service with the court administrator of the district court. Service may be made personally or by mail; service by mail is complete upon mailing; no filing fee shall be required by the court administrator in appeals taken pursuant to this subdivision. MNsure shall furnish all parties to the proceedings with a copy of the decision and a transcript of any testimony, evidence, or other supporting papers from the hearing held before the appeals examiner within 45 days after service of the notice of appeal.

(f) Any party aggrieved by the failure of an adverse party to obey an order issued by MNsure may compel performance according to the order in the manner prescribed in sections 586.01 to 586.12.

(g) Any party may obtain a hearing at a special term of the district court by serving a written notice of the time and place of the hearing at least ten days prior to the date of the hearing. The court may consider the matter in or out of chambers, and shall take no new or additional evidence unless it determines that such evidence is necessary for a more equitable disposition of the appeal.

(h) Any party aggrieved by the order of the district court may appeal the order as in other civil cases. No costs or disbursements shall be taxed against any party nor shall any filing fee or bond be required of any party.

(i) If MNsure or district court orders eligibility for qualified health plan coverage through MNsure, or eligibility for federal advance payment of premium tax credits or cost-sharing reductions contingent upon full payment of respective premiums, the premiums must be paid or provided pending appeal to the district court, Court of Appeals, or Supreme Court. Provision of eligibility by MNsure pending appeal does not render moot MNsure's position in a court of law.

Subd. 7. Agreements; consultation. (a) The board shall:

(1) establish and maintain an agreement with the commissioner of human services for cost allocation and services regarding eligibility determinations and enrollment for public health care programs that use a modified adjusted gross income standard to determine program eligibility.

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The board may establish and maintain an agreement with the commissioner of human services for other services;

(2) establish and maintain an agreement with the commissioners of commerce and health for services regarding enforcement of MNsure certification requirements for health plans and dental plans offered through MNsure. The board may establish and maintain agreements with the commissioners of commerce and health for other services; and

(3) establish interagency agreements to transfer funds to other state agencies for their costs related to implementing and operating MNsure, excluding medical assistance allocatable costs.

(b) The board shall consult with the commissioners of commerce and health regarding the operations of MNsure.

(c) The board shall consult with Indian tribes and organizations regarding the operation of MNsure.

(d) Beginning March 15, 2016, and each March 15 thereafter, the board shall submit a report to the chairs and ranking minority members of the committees in the senate and house of representatives with primary jurisdiction over commerce, health, and human services on all the agreements entered into with the chief information officer of the Office of MN.IT Services, or the commissioners of human services, health, or commerce in accordance with this subdivision. The report shall include the agency in which the agreement is with; the time period of the agreement; the purpose of the agreement; and a summary of the terms of the agreement. A copy of the agreement must be submitted to the extent practicable.

Subd. 8. **Rulemaking.** The board may adopt rules to implement any provisions in this chapter using the expedited rulemaking process in section 14.389.

Subd. 9. **Dental plans.** (a) The provisions of this section that apply to health plans shall apply to dental plans offered as stand-alone dental plans through MNsure, to the extent practicable.

(b) A stand-alone dental plan offered through MNsure must meet all certification requirements under section 1311(c)(1) of the Affordable Care Act, Public Law 111-148, that are applicable to health plans, except for certification requirements that cannot be met because the dental plan only covers dental benefits.

Subd. 10. **Limitations; risk-bearing.** (a) The board shall not bear insurance risk or enter into any agreement with health care providers to pay claims.

(b) Nothing in this subdivision shall prevent MNsure from providing insurance for its employees.

Subd. 11. **Prohibition on other product lines.** MNsure is prohibited from certifying, selecting, or offering products and policies of coverage that do not meet the definition of health plan or dental plan as provided in section 62V.02.

Subd. 12. **Reports on interagency agreements and intra-agency transfers.** The MNsure Board shall provide quarterly reports to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on:

(1) interagency agreements or service-level agreements and any renewals or extensions of existing interagency or service-level agreements with a state department under section 15.01, state agency under section 15.012, or the Office of MN.IT Services, with a value of more than \$100,000, or related agreements with the same department or agency with a cumulative value of more than \$100,000; and

(2) transfers of appropriations of more than \$100,000 between accounts within or between agencies.

The report must include the statutory citation authorizing the agreement, transfer or dollar amount, purpose, and effective date of the agreement, the duration of the agreement, and a copy of the agreement.

62V.051 MNSURE; CONSUMER RETROACTIVE APPOINTMENT OF A NAVIGATOR OR PRODUCER PERMITTED.

Notwithstanding any other law or rule to the contrary, for up to six months after the effective date of the qualified health plan, MNsure must permit a qualified health plan policyholder, who has not designated a navigator or an insurance producer, to retroactively appoint a navigator or insurance producer. MNsure must provide notice of the retroactive appointment to the health carrier. The health carrier must retroactively pay commissions to the insurance producer if the producer can demonstrate that they were certified by MNsure at the time of the original enrollment, were appointed by the selected health carrier at the time of the enrollment, and that an

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agent of record agreement was executed prior to or at the time of the effective date of the policy. MNsure must adopt a standard form of agent of record agreement for purposes of this section.

62V.055 MINNESOTA ELIGIBILITY SYSTEM EXECUTIVE STEERING COMMITTEE.

Subdivision 1. **Definition; Minnesota eligibility system.** For purposes of this section, "Minnesota eligibility system" means the system that supports eligibility determinations using a modified adjusted gross income methodology for medical assistance under section 256B.056, subdivision 1a, paragraph (b), clause (1); MinnesotaCare under chapter 256L; and qualified health plan enrollment under section 62V.05, subdivision 5, paragraph (c).

Subd. 2. **Establishment; committee membership; costs.** (a) The Minnesota Eligibility System Executive Steering Committee is established to provide recommendations to the MNsure board, the commissioner of human services, and the commissioner of MN.IT services on the governance, administration, and business operations of the Minnesota eligibility system. The steering committee shall be composed of:

- (1) two members appointed by the commissioner of human services;
- (2) two members appointed by the board;

(3) two members appointed jointly by the Association of Minnesota Counties, the Minnesota Inter-County Association, and the Minnesota Association of County Social Service Administrators. One member appointed under this clause shall represent counties within the seven-county metropolitan area, and one member shall represent counties outside the seven-county metropolitan area; and

- (4) two nonvoting members appointed by the commissioner of MN.IT services.

(b) One member appointed by the commissioner of human services and one member appointed by the commissioner of MN.IT services shall serve as co-chairpersons for the steering committee.

(c) Steering committee costs must be paid from the budgets of the Department of Human Services, the Office of MN.IT Services, and MNsure.

Subd. 3. **Duties.** The Minnesota Eligibility System Executive Steering Committee shall provide recommendations on an overall governance structure for the Minnesota eligibility system and the ongoing administration and business operations of the Minnesota eligibility system. The steering committee shall make recommendations on setting system goals and priorities, allocating the system's resources, making major system decisions, and tracking total funding and expenditures for the system from all sources. The steering committee shall also report to the Legislative Oversight Committee on a quarterly basis on Minnesota eligibility system funding and expenditures, including amounts received in the most recent quarter by funding source and expenditures made in the most recent quarter by funding source.

Subd. 4. **Meetings.** (a) All meetings of the steering committee must:

(1) be held in the State Office Building, the Minnesota Senate Building, or when approved by the Legislative Oversight Committee, another public location with the capacity to live stream steering committee meetings; and

(2) whenever possible, be made available on a Web site for live audio or video streaming and be archived on a Web site for playback at a later time.

(b) The steering committee must:

(1) as part of every steering committee meeting, provide the opportunity for oral and written public testimony and comments on steering committee recommendations for the governance, administration, and business operations of the Minnesota eligibility system; and

(2) provide documents under discussion or review by the steering committee to be electronically posted on MNsure's Web site. Documents must be provided and posted prior to the meeting at which the documents are scheduled for review or discussion.

(c) All votes of the steering committee must be recorded, with each member's vote identified.

Subd. 5. **Administrative structure.** The Office of MN.IT Services shall be responsible for the design, build, maintenance, operation, and upgrade of the information technology for the Minnesota eligibility system. In carrying out its duties, the office shall consider recommendations made by the steering committee.

62V.06 DATA PRACTICES.

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Subdivision 1. **Applicability.** MNsure is a state agency for purposes of the Minnesota Government Data Practices Act and is subject to all provisions of chapter 13, in addition to the requirements contained in this section.

Subd. 2. **Definitions.** As used in this section:

(1) "individual" means an individual according to section 13.02, subdivision 8, but does not include a vendor of services; and

(2) "participating" means that an individual, employee, or employer is seeking, or has sought an eligibility determination, enrollment processing, or premium processing through MNsure.

Subd. 3. **General data classifications.** The following data collected, created, or maintained by MNsure are classified as private data on individuals, as defined in section 13.02, subdivision 12, or nonpublic data, as defined in section 13.02, subdivision 9:

(1) data on any individual participating in MNsure;

(2) data on any individuals participating in MNsure as employees of an employer participating in MNsure; and

(3) data on employers participating in MNsure.

Subd. 4. **Application and certification data.** (a) Data submitted by an insurance producer in an application for certification to sell a health plan through MNsure, or submitted by an applicant seeking permission or a commission to act as a navigator or in-person assister, are classified as follows:

(1) at the time the application is submitted, all data contained in the application are private data, as defined in section 13.02, subdivision 12, or nonpublic data as defined in section 13.02, subdivision 9, except that the name of the applicant is public; and

(2) upon a final determination related to the application for certification by MNsure, all data contained in the application are public, with the exception of trade secret data as defined in section 13.37.

(b) Data created or maintained by a government entity as part of the evaluation of an application are protected nonpublic data, as defined in section 13.02, subdivision 13, until a final determination as to certification is made and all rights of appeal have been exhausted. Upon a final determination and exhaustion of all rights of appeal, these data are public, with the exception of trade secret data as defined in section 13.37 and data subject to attorney-client privilege or other protection as provided in section 13.393.

(c) If an application is denied, the public data must include the criteria used by the board to evaluate the application and the specific reasons for the denial, and these data must be published on the MNsure Web site.

Subd. 5. **Data sharing.** (a) MNsure may share or disseminate data classified as private or nonpublic in subdivision 3 as follows:

(1) to the subject of the data, as provided in section 13.04;

(2) according to a court order;

(3) according to a state or federal law specifically authorizing access to the data;

(4) with other state or federal agencies, only to the extent necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to an individual, employer, or employee participating in MNsure, provided that MNsure must enter into a data-sharing agreement with the agency prior to sharing data under this clause; and

(5) with a nongovernmental person or entity, only to the extent necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to an individual, employer, or employee participating in MNsure, provided that MNsure must enter into a contract with the person or entity, as provided in section 13.05, subdivision 6 or 11, prior to disseminating data under this clause.

(b) MNsure may share or disseminate data classified as private or nonpublic in subdivision 4 as follows:

(1) to the subject of the data, as provided in section 13.04;

(2) according to a court order;

(3) according to a state or federal law specifically authorizing access to the data;

(4) with other state or federal agencies, only to the extent necessary to carry out the functions of MNsure, provided that MNsure must enter into a data-sharing agreement with the agency prior to sharing data under this clause; and

(5) with a nongovernmental person or entity, only to the extent necessary to carry out the functions of MNsure, provided that MNsure must enter a contract with the person or entity, as provided in section 13.05, subdivision 6 or 11, prior to disseminating data under this clause.

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(c) Sharing or disseminating data outside of MNsure in a manner not authorized by this subdivision is prohibited. The list of authorized dissemination and sharing contained in this subdivision must be included in the Tennessen warning required by section 13.04, subdivision 2.

(d) Until July 1, 2014, state agencies must share data classified as private or nonpublic on individuals, employees, or employers participating in MNsure with MNsure, only to the extent such data are necessary to verify the identity of, determine the eligibility of, process premiums for, process enrollment of, or investigate fraud related to a MNsure participant. The agency must enter into a data-sharing agreement with MNsure prior to sharing any data under this paragraph.

Subd. 6. Notice and disclosures. (a) In addition to the Tennessen warning required by section 13.04, subdivision 2, MNsure must provide any data subject asked to supply private data with:

(1) a notice of rights related to the handling of genetic information, pursuant to section 13.386; and

(2) a notice of the records retention policy of MNsure, detailing the length of time MNsure will retain data on the individual and the manner in which it will be destroyed upon expiration of that time.

(b) All notices required by this subdivision, including the Tennessen warning, must be provided in an electronic format suitable for downloading or printing.

Subd. 7. Summary data. In addition to creation and disclosure of summary data derived from private data on individuals, as permitted by section 13.05, subdivision 7, MNsure may create and disclose summary data derived from data classified as nonpublic under this section.

Subd. 8. Access to data; audit trail. (a) Only individuals with explicit authorization from the board may enter, update, or access not public data collected, created, or maintained by MNsure. The ability of authorized individuals to enter, update, or access data must be limited through the use of role-based access that corresponds to the official duties or training level of the individual, and the statutory authorization that grants access for that purpose. All queries and responses, and all actions in which data are entered, updated, accessed, or shared or disseminated outside of MNsure, must be recorded in a data audit trail. Data contained in the audit trail are public, to the extent that the data are not otherwise classified by this section.

The board shall immediately and permanently revoke the authorization of any individual determined to have willfully entered, updated, accessed, shared, or disseminated data in violation of this section, or any provision of chapter 13. If an individual is determined to have willfully gained access to data without explicit authorization from the board, the board shall forward the matter to the county attorney for prosecution.

(b) This subdivision shall not limit or affect the authority of the legislative auditor to access data needed to conduct audits, evaluations, or investigations of MNsure or the obligation of the board and MNsure employees to comply with section 3.978, subdivision 2.

(c) This subdivision does not apply to actions taken by a MNsure participant to enter, update, or access data held by MNsure, if the participant is the subject of the data that is entered, updated, or accessed.

Subd. 9. Sale of data prohibited. MNsure may not sell any data collected, created, or maintained by MNsure, regardless of its classification, for commercial or any other purposes.

Subd. 10. Gun and firearm ownership. MNsure shall not collect information that indicates whether or not an individual owns a gun or has a firearm in the individual's home.

62V.07 FUNDS.

(a) The MNsure account is created in the special revenue fund of the state treasury. All funds received by MNsure shall be deposited in the account. Funds in the account are appropriated to MNsure for the operation of MNsure. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the MNsure account not currently needed, shall be credited to the MNsure account.

(b) The budget submitted to the legislature under section 16A.11 must include budget information for MNsure.

62V.08 REPORTS.

(a) MNsure shall submit a report to the legislature by January 15, 2015, and each January 15 thereafter, on: (1) the performance of MNsure operations; (2) meeting MNsure responsibilities; (3) an accounting of MNsure budget activities; (4) practices and procedures that have been implemented to ensure compliance with data practices laws, and a description of any violations of

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data practices laws or procedures; and (5) the effectiveness of the outreach and implementation activities of MNsure in reducing the rate of uninsurance.

(b) MNsure must publish its administrative and operational costs on a Web site to educate consumers on those costs. The information published must include: (1) the amount of premiums and federal premium subsidies collected; (2) the amount and source of revenue received under section 62V.05, subdivision 1, paragraph (b), clause (3); (3) the amount and source of any other fees collected for purposes of supporting operations; and (4) any misuse of funds as identified in accordance with section 3.975. The Web site must be updated at least annually.

62V.09 EXPIRATION AND SUNSET EXCLUSION.

Notwithstanding section 15.059, the board and its advisory committees shall not expire, except as specified in section 62V.04, subdivision 13. The board and its advisory committees are not subject to review or sunseting under chapter 3D.

62V.10 RIGHT NOT TO PARTICIPATE.

Nothing in this chapter infringes on the right of a Minnesota citizen not to participate in MNsure.

62V.11 LEGISLATIVE OVERSIGHT COMMITTEE.

Subdivision 1. **Legislative oversight.** (a) The Legislative Oversight Committee is established to provide oversight to the implementation of this chapter and the operation of MNsure.

(b) The committee shall review the operations of MNsure at least annually and shall recommend necessary changes in policy, implementation, and statutes to the board and to the legislature.

(c) MNsure shall present to the committee the annual report required in section 62V.08, the appeals process under section 62V.05, subdivision 6, and the actions taken regarding the treatment of multiemployer plans.

Subd. 2. **Membership; meetings; compensation.** (a) The Legislative Oversight Committee shall consist of five members of the senate, three members appointed by the majority leader of the senate, and two members appointed by the minority leader of the senate; and five members of the house of representatives, three members appointed by the speaker of the house, and two members appointed by the minority leader of the house of representatives.

(b) Appointed legislative members serve at the pleasure of the appointing authority and shall continue to serve until their successors are appointed.

(c) The first meeting of the committee shall be convened by the chair of the Legislative Coordinating Commission. Members shall elect a chair at the first meeting. The chair must convene at least one meeting annually, and may convene other meetings as deemed necessary.

Subd. 4. **Review of costs.** The board shall submit for review the annual budget of MNsure for the next fiscal year by March 15 of each year, beginning March 15, 2014.

Subd. 5. **Review of Minnesota eligibility system funding and expenditures.** The committee shall review quarterly reports submitted by the Minnesota Eligibility System Executive Steering Committee under section 62V.055, subdivision 3, regarding Minnesota eligibility system funding and expenditures.

144.4961 MINNESOTA RADON LICENSING ACT.

Subdivision 1. **Citation.** This section may be cited as the "Minnesota Radon Licensing Act."

Subd. 2. **Definitions.** (a) As used in this section, the following terms have the meanings given them.

(b) "Mitigation" means the act of repairing or altering a building or building design for the purpose in whole or in part of reducing the concentration of radon in the indoor atmosphere.

(c) "Radon" means both the radioactive, gaseous element produced by the disintegration of radium, and the short-lived radionuclides that are decay products of radon.

Subd. 3. **Rulemaking.** The commissioner of health shall adopt rules establishing licensure requirements and work standards relating to indoor radon in dwellings and other buildings, with the exception of newly constructed Minnesota homes according to section 326B.106, subdivision 6. The commissioner shall coordinate, oversee, and implement all state functions in matters concerning the presence, effects, measurement, and mitigation of risks of radon in dwellings and other buildings.

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Subd. 4. **System tag.** All radon mitigation systems installed in Minnesota on or after January 1, 2018, must have a radon mitigation system tag provided by the commissioner. A radon mitigation professional must attach the tag to the radon mitigation system in a visible location.

Subd. 5. **License required annually.** Effective January 1, 2018, a license is required annually for every person, firm, or corporation that performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere.

Subd. 6. **Exemptions.** This section does not apply to:

(1) employees of a firm or corporation that installs radon control systems in newly constructed Minnesota homes as specified in subdivision 11;

(2) a person authorized as a building official under Minnesota Rules, part 1300.0070, or that person's designee; or

(3) any person, firm, corporation, or entity that distributes radon testing devices or information for general educational purposes.

Subd. 7. **License applications and other reports.** The professionals, companies, and laboratories listed in subdivision 8 must submit applications for licenses, system tags, and any other reporting required under this section and Minnesota Rules on forms prescribed by the commissioner.

Subd. 8. **Licensing fees.** (a) All radon license applications submitted to the commissioner of health must be accompanied by the required fees. If the commissioner determines that insufficient fees were paid, the necessary additional fees must be paid before the commissioner approves the application. The commissioner shall charge the following fees for each radon license:

(1) Each measurement professional license, \$150 per year. "Measurement professional" means any person who performs a test to determine the presence and concentration of radon in a building the person does not own or lease.

(2) Each mitigation professional license, \$250 per year. "Mitigation professional" means an individual who installs or designs a radon mitigation system in a building the individual does not own or lease, or provides on-site supervision of radon mitigation and mitigation technicians. "On-site supervision" means a review at the property of mitigation work upon completion of the work and attachment of a system tag. Employees or subcontractors who are supervised by a licensed mitigation professional are not required to be licensed under this clause. This license also permits the licensee to perform the activities of a measurement professional described in clause (1).

(3) Each mitigation company license, \$100 per year. "Mitigation company" means any business or government entity that performs or authorizes employees to perform radon mitigation. This fee is waived if the mitigation company employs only one licensed mitigation professional.

(4) Each radon analysis laboratory license, \$500 per year. "Radon analysis laboratory" means a business entity or government entity that analyzes passive radon detection devices to determine the presence and concentration of radon in the devices. This fee is waived if the laboratory is a government entity and is only distributing test kits for the general public to use in Minnesota.

(5) Each Minnesota Department of Health radon mitigation system tag, \$75 per tag. "Minnesota Department of Health radon mitigation system tag" or "system tag" means a unique identifiable radon system label provided by the commissioner of health.

(b) Fees collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 9. **Enforcement.** The commissioner shall enforce this section under the provisions of sections 144.989 to 144.993.

Subd. 10. **Local inspections or permits.** This section does not preclude local units of government from requiring additional permits or inspections for radon control systems, and does not supersede any local inspection or permit requirements.

Subd. 11. **Application; newly constructed homes.** This section does not apply to newly constructed Minnesota homes according to section 326B.106, subdivision 6, prior to the issuance of a certificate of occupancy.

144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS: REPORT AND STUDY REQUIRED.

Subd. 2. **Critical access study.** The commissioner of human services shall conduct a onetime study to assess local capacity and availability of home and community-based services for older adults, people with disabilities, and people with mental illnesses. The study must assess critical access at the community level and identify potential strategies to build home and

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community-based service capacity in critical access areas. The report shall be submitted to the legislature no later than August 15, 2015.

147.0375 MEDICAL FACULTY LICENSE.

Subd. 7. **Expiration.** This section expires July 1, 2018.

147A.21 RULEMAKING AUTHORITY.

The board shall adopt rules:

- (1) setting license fees;
- (2) setting renewal fees;
- (3) setting fees for temporary licenses; and
- (4) establishing renewal dates.

147B.08 FEES.

Subdivision 1. **Annual registration fee.** The board shall establish the fee of \$150 for initial licensure and \$150 annual licensure renewal. The board may prorate the initial licensure fee.

Subd. 2. **Penalty fee for late renewals.** The penalty fee for late submission for renewal application is \$50.

Subd. 3. **Deposit.** Fees collected by the board under this section must be deposited in the state government special revenue fund.

147C.40 FEES.

Subdivision 1. **Fees.** The board shall adopt rules setting:

- (1) licensure fees;
- (2) renewal fees;
- (3) late fees;
- (4) inactive status fees; and
- (5) fees for temporary permits.

Subd. 2. **Proration of fees.** The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal.

Subd. 3. **Penalty fee for late renewals.** An application for license renewal submitted after the deadline must be accompanied by a late fee in addition to the required fees.

Subd. 4. **Nonrefundable fees.** All of the fees in subdivision 1 are nonrefundable.

148.6402 DEFINITIONS.

Subd. 2. **Advisory council.** "Advisory council" means the Occupational Therapy Practitioners Advisory Council in section 148.6450.

148.6450 OCCUPATIONAL THERAPY PRACTITIONERS ADVISORY COUNCIL.

Subdivision 1. **Membership.** The commissioner shall appoint seven persons to an Occupational Therapy Practitioners Advisory Council consisting of the following:

(1) two public members, as defined in section 214.02. The public members shall be either persons who have received occupational therapy services or family members of or caregivers to such persons;

(2) two members who are occupational therapists and two occupational therapy assistants licensed under sections 148.6401 to 148.6450, each of whom is employed in a different practice area including, but not limited to, long-term care, school therapy, early intervention, administration, gerontology, industrial rehabilitation, cardiac rehabilitation, physical disability, pediatrics, mental health, home health, and hand therapy. Three of the four occupational therapy practitioners who serve on the advisory council must be currently, and for the three years preceding the appointment, engaged in the practice of occupational therapy or employed as an administrator or an instructor of an occupational therapy program. At least one of the four occupational therapy practitioners who serves on the advisory council must be employed in a rural area; and

(3) one member who is a licensed or registered health care practitioner, or other credentialed practitioner, who works collaboratively with occupational therapy practitioners.

Subd. 2. **Duties.** At the commissioner's request, the advisory council shall:

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- (1) advise the commissioner regarding the occupational therapy practitioner licensure standards;
- (2) advise the commissioner on enforcement of sections 148.6401 to 148.6450;
- (3) provide for distribution of information regarding occupational therapy practitioners licensure standards;
- (4) review applications and make recommendations to the commissioner on granting or denying licensure or licensure renewal;
- (5) review reports of investigations relating to individuals and make recommendations to the commissioner as to whether licensure should be denied or disciplinary action taken against the person; and
- (6) perform other duties authorized for advisory councils by chapter 214, as directed by the commissioner.

148.906 LEVELS OF PRACTICE.

The board may grant licenses for levels of psychological practice to be known as (1) licensed psychologist and (2) licensed psychological practitioner.

148.907 LICENSED PSYCHOLOGIST.

Subd. 5. **Converting from licensed psychological practitioner to licensed psychologist.** Notwithstanding subdivision 3, to convert from licensure as a licensed psychological practitioner to licensure as a licensed psychologist, a licensed psychological practitioner shall have:

- (1) completed an application provided by the board for conversion from licensure as a licensed psychological practitioner to licensure as a licensed psychologist;
- (2) paid a nonrefundable fee of \$500;
- (3) documented successful completion of two full years, or the equivalent, of supervised postlicensure employment meeting the requirements of section 148.925, subdivision 5, as it relates to preparation for licensure as a licensed psychologist as follows:
 - (i) for individuals licensed as licensed psychological practitioners on or before December 31, 2006, the supervised practice must be completed by December 31, 2010; and
 - (ii) for individuals licensed as licensed psychological practitioners after December 31, 2006, the supervised practice must be completed within four years from the date of licensure; and
- (4) no unresolved disciplinary action or complaints pending, or incomplete disciplinary orders or corrective action agreements in Minnesota or any other jurisdiction.

148.908 LICENSED PSYCHOLOGICAL PRACTITIONER.

Subdivision 1. **Scope of practice.** A licensed psychological practitioner shall practice only under supervision that satisfies the requirements of section 148.925 and while employed by either a licensed psychologist or a health care or social service agency which employs or contracts with a supervising licensed psychologist who shares clinical responsibility for the care provided by the licensed psychological practitioner.

Subd. 2. **Requirements for licensure as licensed psychological practitioner.** To become licensed by the board as a licensed psychological practitioner, an applicant shall comply with the following requirements:

- (1) have earned a doctoral or master's degree or the equivalent of a master's degree in a doctoral program with a major in psychology from a regionally accredited educational institution meeting the standards the board has established by rule. The degree requirements must be completed by December 31, 2005;
- (2) complete an application for admission to the examination for professional practice in psychology and pay the nonrefundable application fee by December 31, 2005;
- (3) complete an application for admission to the professional responsibility examination and pay the nonrefundable application fee by December 31, 2005;
- (4) pass the examination for professional practice in psychology by December 31, 2006;
- (5) pass the professional responsibility examination by December 31, 2006;
- (6) complete an application for licensure as a licensed psychological practitioner and pay the nonrefundable application fee by March 1, 2007; and
- (7) have attained the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction.

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Subd. 3. **Termination of licensure.** Effective December 31, 2011, the licensure of all licensed psychological practitioners shall be terminated without further notice and licensure as a licensed psychological practitioner in Minnesota shall be eliminated.

148.909 LICENSURE FOR VOLUNTEER PRACTICE.

Subd. 7. **Continuing education requirements.** A provider licensed under this section is subject to the same continuing education requirements as a licensed psychologist under section 148.911.

148.96 PRESENTATION TO PUBLIC.

Subd. 4. **Persons or techniques not regulated by this board.** (a) Nothing in sections 148.88 to 148.98 shall be construed to limit the occupational pursuits consistent with their training and codes of ethics of professionals such as teachers in recognized public and private schools, members of the clergy, physicians, social workers, school psychologists, alcohol or drug counselors, optometrists, or attorneys. However, in such performance any title used shall be in accordance with section 148.96.

(b) Use of psychological techniques by business and industrial organizations for their own personnel purposes or by employment agencies or state vocational rehabilitation agencies for the evaluation of their own clients prior to recommendation for employment is also specifically allowed. However, no representative of an industrial or business firm or corporation may sell, offer, or provide any psychological services as specified in section 148.89 unless such services are performed or supervised by individuals licensed under sections 148.88 to 148.98.

Subd. 5. **Other professions not authorized.** Nothing in sections 148.88 to 148.98 shall be construed to authorize a person licensed under sections 148.88 to 148.98 to engage in the practice of any profession regulated under Minnesota law unless the person is duly licensed or registered in that profession.

179A.50 REPRESENTATION OF FAMILY CHILD CARE PROVIDERS.

Sections 179A.50 to 179A.52 shall be known as the Family Child Care Providers Representation Act.

179A.51 DEFINITIONS.

Subdivision 1. **Scope.** For the purposes of sections 179A.50 to 179A.52, the terms in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of mediation services.

Subd. 3. **Exclusive representative.** "Exclusive representative" means an employee organization that has been elected and certified under section 179A.52, thereby maintaining the right to represent family child care providers in their relations with the state.

Subd. 4. **Family child care provider.** "Family child care provider" means an individual, either licensed or unlicensed, who provides legal child care services as defined under section 245A.03, except for providers licensed under Minnesota Rules, chapter 9503, or excluded from licensure under section 245A.03, subdivision 2, paragraph (a), clause (5), and who receives child care assistance to subsidize child care services for a child or children currently in the individual's care, under sections 119B.03; 119B.05; and 119B.011, subdivisions 20 and 20a.

179A.52 RIGHT TO ORGANIZE.

Subdivision 1. **Rights of individual providers and participants.** For the purposes of the Public Employment Labor Relations Act, under chapter 179A, family child care providers shall be considered, by virtue of this section, executive branch state employees employed by the commissioner of management and budget or the commissioner's representative. This section does not require the treatment of family child care providers as public employees for any other purpose. Family child care providers are not state employees for purposes of section 3.736. Chapter 179A shall apply to family child care providers except as otherwise provided in this section. Notwithstanding section 179A.03, subdivision 14, paragraph (a), clause (5), chapter 179A shall apply to family child care providers regardless of part-time or full-time employment status. Family child care providers shall not have the right to strike.

Subd. 2. **Appropriate unit.** The only appropriate unit under this section shall be a statewide unit of all family child care providers who meet the definition in section 179A.51, and who have

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had an active registration under chapter 119B within the previous 12 months. The unit shall be treated as an appropriate unit under section 179A.10, subdivision 2.

Subd. 3. **Compilation of list.** The commissioner of human services shall, by July 1, 2013, and monthly thereafter, compile and maintain a list of the names and addresses of all family child care providers who meet the definition in section 179A.51, and who have had an active registration under chapter 119B within the previous 12 months. The list shall not include the name of any participant, or indicate that an individual provider is a relative of a participant or has the same address as a participant. The commissioner of human services shall share the lists with others as needed for the state to meet its obligations under chapter 179A as modified and made applicable to family child care providers under this section, and to facilitate the representational processes under this section.

Subd. 4. **List access.** Beginning July 1, 2013, upon a showing made to the commissioner of the Bureau of Mediation Services by any employee organization wishing to represent the appropriate unit of family child care providers that at least 500 family child care providers support such representation, the commissioner of human services shall provide to such organization within seven days the most recent list of actively registered family child care providers compiled under subdivision 3, and subsequent monthly lists upon request for an additional three months. When the list is made available to an employee organization under this subdivision, the list must be made publicly available.

Subd. 5. **Elections for exclusive representative.** After July 31, 2013, any employee organization wishing to represent the appropriate unit of family child care providers may seek exclusive representative status pursuant to section 179A.12. Certification elections for family child care providers shall be conducted by mail ballot, and such election shall be conducted upon an appropriate petition stating that at least 30 percent of the appropriate unit wishes to be represented by the petitioner. The family child care providers eligible to vote in any such election shall be those family child care providers on the monthly list of family child care providers compiled under this section, most recently preceding the filing of the election petition. Except as otherwise provided, elections under this subdivision shall be conducted in accordance with section 179A.12.

Subd. 6. **Meet and negotiate.** If the commissioner certifies an employee organization as the majority exclusive representative, the state, through the governor or the governor's designee, shall meet and negotiate in good faith with the exclusive representative of the family child care provider unit regarding grievance issues, child care assistance reimbursement rates under chapter 119B, and terms and conditions of service, but this obligation does not compel the state or its representatives to agree to a proposal or require the making of a concession. The governor or the governor's designee is authorized to enter into agreements with the exclusive representative. Negotiated agreements and arbitration decisions must be submitted to the legislature to be accepted or rejected in accordance with sections 3.855 and 179A.22.

Subd. 7. **Meet and confer.** The state has an obligation to meet and confer under chapter 179A with family child care providers to discuss policies and other matters relating to their service that are not terms and conditions of service.

Subd. 8. **Terms and conditions of service.** For purposes of this section, "terms and conditions of service" has the same meaning as given in section 179A.03, subdivision 19.

Subd. 9. **Rights.** Nothing in this section shall be construed to interfere with:

(1) parental rights to select and deselect family child care providers or the ability of family child care providers to establish the rates they charge to parents;

(2) the right or obligation of any state agency to communicate or meet with any citizen or organization concerning family child care legislation, regulation, or policy; or

(3) the rights and responsibilities of family child care providers under federal law.

Subd. 10. **Membership status and eligibility for subsidies.** Membership status in an employee organization shall not affect the eligibility of a family child care provider to receive payments under, or serve a child who receives payments under, chapter 119B.

179A.53 NO USE OF SCHOLARSHIPS FOR DUES OR FEES.

Early learning scholarships shall not be applied, through state withholding or otherwise, toward payment of dues or fees that are paid to exclusive representatives of family child care providers.

245A.1915 OPIOID ADDICTION TREATMENT EDUCATION REQUIREMENT FOR PROVIDERS LICENSED TO PROVIDE CHEMICAL DEPENDENCY TREATMENT SERVICES.

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All programs serving persons with substance use issues licensed by the commissioner must provide educational information concerning: treatment options for opioid addiction, including the use of a medication for the use of opioid addiction; and recognition of and response to opioid overdose and the use and administration of naloxone, to clients identified as having or seeking treatment for opioid addiction. The commissioner shall develop educational materials that are supported by research and updated periodically that must be used by programs to comply with this requirement.

245A.192 PROVIDERS LICENSED TO PROVIDE TREATMENT OF OPIOID ADDICTION.

Subdivision 1. **Scope.** (a) This section applies to services licensed under this chapter to provide treatment for opioid addiction. In addition to the requirements under Minnesota Rules, parts 9530.6405 to 9530.6505, a program licensed to provide treatment of opioid addiction must meet the requirements in this section.

(b) Where a standard in this section differs from a standard in an otherwise applicable administrative rule, the standards of this section apply.

(c) When federal guidance or interpretations have been issued on federal standards or requirements also required under this section, the federal guidance or interpretations shall apply.

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Diversion" means the use of a medication for the treatment of opioid addiction being diverted from its intended use.

(c) "Guest dose or dosing" means the practice of administering a medication used for the treatment of opioid addiction to a person who is not a client of the program that is administering or dispensing the medication.

(d) "Medical director" means a physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program, either by performing them directly or by delegating specific responsibility to authorized program physicians and health care professionals functioning under the medical director's direct supervision.

(e) "Medication used for the treatment of opioid addiction" means a medication approved by the Food and Drug Administration for the treatment of opioid addiction.

(f) "Opioid treatment program" has the meaning given in Code of Federal Regulations, title 42, section 8.12, and includes programs licensed under Minnesota Rules, part 9530.6500.

(g) "Program" means an entity that is licensed under Minnesota Rules, part 9530.6500.

(h) "Unsupervised use" means the use of a medication for the treatment of opioid addiction dispensed for use by a client outside of the program setting. This is also referred to as a "take-home" dose.

(i) "Placing authority" has the meaning given in Minnesota Rules, part 9530.6605, subpart 21a.

(j) "Minnesota health care programs" has the meaning given in section 256B.0636.

Subd. 3. **Medication orders.** Prior to the program administering or dispensing a medication used for the treatment of opioid addiction:

(1) a client-specific order must be received from an appropriately credentialed physician who is enrolled as a Minnesota health care programs provider and meets all applicable provider standards;

(2) the signed order must be documented in the client's record; and

(3) if the physician that issued the order is not able to sign the order when issued, the unsigned order must be entered in the client record at the time it was received, and the physician must review the documentation and sign the order in the client's record within 72 hours of the medication being ordered. The license holder must report to the commissioner any medication error that endangers a patient's health, as determined by the medical director.

Subd. 3a. **High dose requirements.** A client being administered or dispensed a dose beyond that set forth in subdivision 5, paragraph (a), clause (1), that exceeds 150 milligrams of methadone or 24 milligrams of buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing physician. The meeting must occur before the administering or dispensing of the increased dose.

Subd. 4. **Drug testing.** Each client enrolled in the program must receive a minimum of eight random drug abuse tests per 12 months of treatment. These tests must be reasonably disbursed over the 12-month period. A license holder may elect to conduct more drug abuse tests.

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Subd. 5. **Criteria for unsupervised use.** (a) To limit the potential for diversion of medication used for the treatment of opioid addiction to the illicit market, any such medications dispensed to patients for unsupervised use shall be subject to the following requirements:

(1) any patient in an opioid treatment program may receive a single take-home dose for a day that the clinic is closed for business, including Sundays and state and federal holidays; and

(2) treatment program decisions on dispensing medications used to treat opioid addiction to patients for unsupervised use beyond that set forth in clause (1) shall be determined by the medical director.

(b) A physician with authority to prescribe must consider the criteria in this subdivision in determining whether a client may be permitted unsupervised or take-home use of such medications. The criteria must also be considered when determining whether dispensing medication for a client's unsupervised use is appropriate to increase or to extend the amount of time between visits to the program. The criteria include:

(1) absence of recent abuse of drugs including but not limited to opioids, nonnarcotics, and alcohol;

(2) regularity of program attendance;

(3) absence of serious behavioral problems at the program;

(4) absence of known recent criminal activity such as drug dealing;

(5) stability of the client's home environment and social relationships;

(6) length of time in comprehensive maintenance treatment;

(7) reasonable assurance that take-home medication will be safely stored within the client's home; and

(8) whether the rehabilitative benefit the client derived from decreasing the frequency of program attendance outweighs the potential risks of diversion or unsupervised use.

(c) The determination, including the basis of the determination, must be consistent with the criteria in this subdivision and must be documented in the client's medical record.

Subd. 6. **Restrictions for unsupervised or take-home use of methadone hydrochloride.**

(a) In cases where it is determined that a client meets the criteria in subdivision 5 and may be dispensed a medication used for the treatment of opioid addiction, the restrictions in paragraphs (b) to (g) must be followed when the medication to be dispensed is methadone hydrochloride.

(b) During the first 90 days of treatment, the take-home supply must be limited to a maximum of a single dose each week and the client shall ingest all other doses under direct supervision.

(c) In the second 90 days of treatment, the take-home supply must be limited to two doses per week.

(d) In the third 90 days of treatment, the take-home supply must not exceed three doses per week.

(e) In the remaining months of the first year, a client may be given a maximum six-day supply of take-home medication.

(f) After one year of continuous treatment, a client may be given a maximum two-week supply of take-home medication.

(g) After two years of continuous treatment, a client may be given a maximum one-month supply of take-home medication, but must make monthly visits.

Subd. 7. **Restriction exceptions.** When a license holder has reason to accelerate the number of unsupervised or take-home doses of methadone hydrochloride, the license holder must comply with the requirements of Code of Federal Regulations, title 42, section 8.12, the criteria for unsupervised use in subdivision 5, and must use the exception process provided by the federal Center for Substance Abuse Treatment Division of Pharmacologic Therapies. For the purposes of enforcement of this subdivision, the commissioner has the authority to monitor for compliance with these federal regulations and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 8. **Guest dosing.** In order to receive a guest dose, the client must be enrolled in an opioid treatment program elsewhere in the state or country and be receiving the medication on a temporary basis because the client is not able to receive the medication at the program in which the client is enrolled. Such arrangements shall not exceed 30 consecutive days in any one program and must not be for the convenience or benefit of either program. Guest dosing may also occur when the client's primary clinic is not open and the client is not receiving take-home doses.

Subd. 9. **Data and reporting.** The license holder must submit data concerning medication used for the treatment of opioid addiction to a central registry. The data must be submitted in a method determined by the commissioner and must be submitted for each client at the time of admission and discharge. The program must document the date the information was submitted. This requirement is effective upon implementation of changes to the Drug and Alcohol Abuse

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Normative Evaluation System (DAANES) or development of an electronic system by which to submit the data.

Subd. 10. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in Minnesota Rules, part 9530.6430, subpart 1, item A, subitem (1), per week, for the first ten weeks following admission, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) Notwithstanding the requirements of comprehensive assessments in Minnesota Rules, part 9530.6422, the assessment must be completed within 21 days of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in Minnesota Rules, part 9530.6425:

(1) treatment plan contents for maintenance clients are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for clients in a taper or detox status must include goals the client must reach to complete treatment and have services terminated;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes must be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress no less than one time monthly, recorded in the six dimensions or when clinical need warrants more frequent notations; and

(4) upon the development of the treatment plan and thereafter, treatment plan reviews must occur weekly, or after each treatment service, whichever is less frequent, for the first ten weeks after the treatment plan is developed. Following the first ten weeks of treatment plan reviews, reviews may occur monthly, unless the client has needs that warrant more frequent revisions or documentation.

Subd. 11. **Prescription monitoring program.** (a) The program must develop and maintain a policy and procedure that requires the ongoing monitoring of the data from the prescription monitoring program for each client. The policy and procedure must include how the program will meet the requirements in paragraph (b).

(b) If a medication used for the treatment of opioid addiction is administered or dispensed to a client, the license holder shall be subject to the following requirements:

(1) upon admission to a methadone clinic outpatient treatment program, clients must be notified in writing that the commissioner of human services and the medical director will monitor the prescription monitoring program to review the prescribed controlled drugs the clients have received;

(2) the medical director or the medical director's delegate must review the data from the Minnesota Board of Pharmacy prescription monitoring program (PMP) established under section 152.126 prior to the client being ordered any controlled substance, as defined under section 152.126, subdivision 1, paragraph (c), including medications used for the treatment of opioid addiction, and subsequent reviews of the PMP data must occur at least every 90 days;

(3) a copy of the PMP data reviewed must be maintained in the client file;

(4) when the PMP data contains a recent history of multiple prescribers or multiple prescriptions for controlled substances, the physician's review of the data and subsequent actions must be documented in the client's individual file within 72 hours and must contain the medical director's determination of whether or not the prescriptions place the client at risk of harm and the actions to be taken in response to the PMP findings. In addition, the provider must conduct subsequent reviews of the PMP on a monthly basis; and

(5) if at any time the medical director believes the use of the controlled substances places the client at risk of harm, the program must seek the client's consent to discuss the client's opioid treatment with other prescribers and must seek consent for the other prescriber to disclose to the opioid treatment program's medical director the client's condition that formed the basis of the other prescriptions. If the information is not obtained within seven days, the medical director must document whether or not changes to the client's medication dose or number of take-home doses are necessary until the information is obtained.

(c) The commissioner shall collaborate with the Minnesota Board of Pharmacy to develop and implement an electronic system through which the commissioner shall routinely access the data from the Minnesota Board of Pharmacy prescription monitoring program established under section 152.126 for the purpose of determining whether any client enrolled in an opioid addiction

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treatment program licensed according to this section has also been prescribed or dispensed a controlled substance in addition to that administered or dispensed by the opioid addiction treatment program. When the commissioner determines there have been multiple prescribers or multiple prescriptions of controlled substances, the commissioner shall:

(1) inform the medical director of the opioid treatment program only that the commissioner determined the existence of multiple prescribers or multiple prescriptions of controlled substances; and

(2) direct the medical director of the opioid treatment program to access the data directly, review the effect of the multiple prescribers or multiple prescriptions, and document the review.

(d) If determined necessary, the commissioner shall seek a federal waiver of, or exception to, any applicable provision of Code of Federal Regulations, title 42, section 2.34(c), prior to implementing this subdivision.

Subd. 12. Policies and procedures. (a) License holders must develop and maintain the policies and procedures required in this subdivision.

(b) For programs that are not open every day of the year, the license holder must maintain a policy and procedure that permits clients to receive a single unsupervised use of medication used for the treatment of opioid addiction for days that the program is closed for business, including, but not limited to, Sundays and state and federal holidays as required under subdivision 5, paragraph (a), clause (1).

(c) The license holder must maintain a policy and procedure that includes specific measures to reduce the possibility of medication used for the treatment of opioid addiction being diverted from its intended treatment use. The policy and procedure must:

(1) specifically identify and define the responsibilities of the medical and administrative staff for carrying out diversion control measures; and

(2) include a process for contacting no less than five percent of clients who have unsupervised use of medication used for the treatment of opioid addiction, excluding those approved solely under subdivision 5, paragraph (a), clause (1), to require them to physically return to the program each month. The system must require clients to return to the program within a stipulated time frame and turn in all unused medication containers related to opioid addiction treatment. The license holder must document all related contacts on a central log and the outcome of the contact for each client in the individual client's record.

(d) Medications used for the treatment of opioid addictions must be ordered, administered, and dispensed according to applicable state and federal regulations and the standards set by applicable accreditation entities. In addition, when an order requires assessment by the person administering or dispensing the medication to determine the amount to be administered or dispensed, the assessment must be completed by an individual whose professional scope of practice permits such assessment. For the purposes of enforcement of this paragraph, the commissioner has the authority to monitor for compliance with these state and federal regulations and the relevant standards of the license holder's accreditation agency and may issue licensing actions according to sections 245A.05, 245A.06, and 245A.07 based on the commissioner's determination of noncompliance.

Subd. 13. Quality improvement plan. The license holder must develop and maintain a quality improvement process and plan. The plan must:

(1) include evaluation of the services provided to clients with the goal of identifying issues that may improve service delivery and client outcomes;

(2) include goals for the program to accomplish based on the evaluation;

(3) be reviewed annually by the management of the program to determine whether the goals were met and, if not, whether additional action is required;

(4) be updated at least annually to include new or continued goals based on an updated evaluation of services; and

(5) identify two specific goal areas, in addition to others identified by the program, including:

(i) a goal concerning oversight and monitoring of the premises around and near the exterior of the program to reduce the possibility of medication used for the treatment of opioid addiction being inappropriately used by clients, including but not limited to the sale or transfer of the medication to others; and

(ii) a goal concerning community outreach, including but not limited to communications with local law enforcement and county human services agencies, with the goal of increasing coordination of services and identification of areas of concern to be addressed in the plan.

Subd. 14. Placing authorities. Programs must provide certain notification and client-specific updates to placing authorities for clients who are enrolled in Minnesota health care programs. At the request of the placing authority, the program must provide client-specific updates, including

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but not limited to informing the placing authority of positive drug screenings and changes in medications used for the treatment of opioid addiction ordered for the client.

Subd. 15. **A program's duty to report suspected drug diversion.** (a) To the fullest extent permitted under Code of Federal Regulations, title 42, sections 2.1 to 2.67, a program shall report to law enforcement any credible evidence that the program or its personnel knows, or reasonably should know, that is directly related to a diversion crime on the premises of the program, or a threat to commit a diversion crime.

(b) "Diversion crime," for the purposes of this section, means diverting, attempting to divert, or conspiring to divert Schedule I, II, III, or IV drugs, as defined in section 152.02, on the program's premises.

(c) The program must document its compliance with the requirement in paragraph (a) in either a client's record or an incident report.

(d) Failure to comply with the duty in paragraph (a) may result in sanctions as provided in sections 245A.06 and 245A.07.

Subd. 16. **Variance.** The commissioner may grant a variance to the requirements of this section.

254A.02 DEFINITIONS.

Subd. 4. **Drug abuse or abuse of drugs.** "Drug abuse or abuse of drugs" is the use of any psychoactive or mood altering chemical substance, without compelling medical reason, in such a manner as to induce mental, emotional or physical impairment and cause socially dysfunctional or socially disordering behavior and which results in psychological or physiological dependency as a function of continued use.

256B.4914 HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.

Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following adjustments to the rate generated by the framework to assure budget neutrality until the rate information is available to implement paragraph (b). The rate generated by the framework shall be multiplied by the appropriate factor, as designated below:

(1) for residential services: 1.003;

(2) for day services: 1.000;

(3) for unit-based services with programming: 0.941; and

(4) for unit-based services without programming: 0.796.

(b) Within 12 months of January 1, 2014, the commissioner shall compare estimated spending for all home and community-based waiver services under the new payment rates defined in subdivisions 6 to 9 with estimated spending for the same recipients and services under the rates in effect on July 1, 2013. This comparison must distinguish spending under each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and services for one or more service months after the new rates have gone into effect. The commissioner shall consult with the commissioner of management and budget on this analysis to ensure budget neutrality. If estimated spending under the new rates for services under one or more subdivisions differs in this comparison by 0.3 percent or more, the commissioner shall assure aggregate budget neutrality across all service areas by adjusting the budget neutrality factor in paragraph (a) in each subdivision so that total estimated spending for each subdivision under the new rates matches estimated spending under the rates in effect on July 1, 2013.

256B.64 ATTENDANTS TO VENTILATOR-DEPENDENT RECIPIENTS.

A ventilator-dependent recipient of medical assistance who has been receiving the services of a home care nurse or personal care assistant in the recipient's home may continue to have a home care nurse or personal care assistant present upon admission to a hospital licensed under chapter 144. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent patient during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient. The personal care assistant or home care nurse may offer nonbinding advice to the health care professionals in charge of the ventilator-dependent patient's care and treatment on matters pertaining to the comfort and safety of the patient. Within 36 hours of the end of the 120-hour transition period, an assessment may be made by the ventilator-dependent recipient, the attending physician, and the hospital staff caring for the recipient. If the persons making the assessment determine that

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additional communicator or interpreter services are medically necessary, the hospital must contact the commissioner 24 hours prior to the end of the 120-hour transition period and submit the assessment information to the commissioner. The commissioner shall review the request and determine if it is medically necessary to continue the interpreter services or if the hospital staff has had sufficient opportunity to adequately determine the needs of the patient. The commissioner shall determine if continued service is necessary and appropriate and whether or not payments shall continue. The commissioner may not authorize services beyond the limits of the available appropriations for this section. The commissioner may adopt rules necessary to implement this section. Reimbursement under this section must be at the payment rate and in a manner consistent with the payment rate and manner used in reimbursing these providers for home care services for the ventilator-dependent recipient under the medical assistance program.

256B.7631 CHEMICAL DEPENDENCY PROVIDER RATE INCREASE.

For the chemical dependency services listed in section 254B.05, subdivision 5, and provided on or after July 1, 2015, payment rates shall be increased by two percent over the rates in effect on January 1, 2014, for vendors who meet the requirements of section 254B.05.

256C.23 DEFINITIONS.

Subd. 3. **Regional service center.** "Regional service center" means a facility designed to provide an entry point for deaf, deafblind, and hard-of-hearing persons of that region in need of education, employment, social, human, or other services.

256C.233 DUTIES OF STATE AGENCIES.

Subd. 4. **State commissioners.** The commissioners of all state agencies shall consult with the Deaf and Hard-of-Hearing Services Division concerning the promulgation of public policies, regulations, and programs necessary to address the needs of deaf, deafblind, and hard-of-hearing Minnesotans. Each state agency shall consult with the Deaf and Hard-of-Hearing Services Division concerning the need to forward legislative initiatives to the governor to address the concerns of deaf, deafblind, and hard-of-hearing Minnesotans.

256C.25 INTERPRETER SERVICES.

Subdivision 1. **Establishment.** The Deaf and Hard-of-Hearing Services Division shall maintain and coordinate statewide interpreting or interpreter referral services for use by any public or private agency or individual in the state. The division shall directly coordinate these services but may contract with an appropriate agency to provide this service. The division may collect a \$3 fee per referral for interpreter referral services and the actual costs of interpreter services provided by department staff. Fees and payments collected shall be deposited in the general fund. The \$3 referral fee shall not be collected from state agencies or local units of government or deaf or hard-of-hearing consumers or interpreters.

Subd. 2. **Duties.** Interpreting or interpreter referral services must include:

- (1) statewide access to interpreter referral and direct interpreting services, coordinated with the regional service centers;
- (2) maintenance of a statewide directory of qualified interpreters;
- (3) assessment of the present and projected supply and demand for interpreter services statewide; and
- (4) coordination with the regional service centers on projects to train interpreters and advocate for and evaluate interpreter services.

256J.626 MFIP CONSOLIDATED FUND.

Subd. 5. **Innovation projects.** Beginning January 1, 2005, no more than \$3,000,000 of the funds annually appropriated to the commissioner for use in the consolidated fund shall be available to the commissioner to reward high-performing counties and tribes, support promising practices, and test innovative approaches to improving outcomes for MFIP participants, family stabilization services participants, and persons at risk of receiving MFIP as detailed in subdivision 3. Project funds may be targeted to geographic areas with poor outcomes as specified in section 256J.751, subdivision 5, or to subgroups within the MFIP case load who are experiencing poor outcomes.

Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter 312, article 27, section 72; as amended by Laws 2015, chapter 71, article 7, section 58; as amended by Laws 2016, chapter 144, section 1

Sec. 72. Laws 2012, chapter 247, article 4, section 47, is amended to read:

Sec. 47. **COMMISSIONER TO SEEK AMENDMENT FOR EXCEPTION TO CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY.**

By July 1, 2014, if necessary, the commissioner shall request an amendment to the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to establish an exception to the consumer-directed community supports budget methodology to provide up to 20 percent more funds for those participants who have their 21st birthday and graduate from high school between 2013 to 2015 and are authorized for more services under consumer-directed community supports prior to graduation than the amount they are eligible to receive under the current consumer-directed community supports budget methodology. The exception is limited to those who can demonstrate that they will have to leave consumer-directed community supports and use other waiver services because their need for day or employment supports cannot be met within the consumer-directed community supports budget limits. The commissioner shall consult with the stakeholder group authorized under Minnesota Statutes, section 256B.0657, subdivision 11, to implement this provision. The exception process shall be effective upon federal approval for persons eligible through June 30, 2017.

Laws 2014, chapter 312, article 23, section 9, subdivision 5

Sec. 9. **LEGISLATIVE HEALTH CARE WORKFORCE COMMISSION.**

Subd. 5. **Report to the legislature.** The Legislative Health Care Workforce Commission must provide a preliminary report making recommendations to the legislature by December 31, 2014. The commission must provide a final report to the legislature by December 31, 2016. The final report must:

(1) identify current and anticipated health care workforce shortages, by both provider type and geography;

(2) evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce;

(3) study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce; and

(4) identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:

(i) training and residency shortages;

(ii) disparities in income between primary care and other providers; and

(iii) negative perceptions of primary care among students.

Laws 2015, chapter 71, article 7, section 54

Sec. 54. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, 2015, if necessary, the commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to establish an exception to the consumer-directed community supports budget methodology to provide up to 20 percent more funds for:

(1) consumer-directed community supports participants who have graduated from high school and have a coordinated service and support plan which identifies the need for more services under consumer-directed community supports, either prior to graduation or in order to increase the amount of time a person works or to improve their employment opportunities, than the amount they are eligible to receive under the current consumer-directed community supports budget methodology; and

(2) home and community-based waiver participants who are currently using licensed services for employment supports or services during the day which cost more annually than the person would spend under a consumer-directed community supports plan for individualized employment supports or services during the day.

(b) The exception under paragraph (a) is limited to those persons who can demonstrate either that they will have to leave consumer-directed community supports and use other waiver services because their need for day or employment supports cannot be met within the

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consumer-directed community supports budget limits or they will move to consumer-directed community supports and their services will cost less than services currently being used.

EFFECTIVE DATE. The exception under this section is effective October 1, 2015, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when this occurs.

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5600.2500 FEES.

The fees charged by the board are fixed at the following rates:

- A. physician application fee, \$200;
- B. physician annual license, \$192;
- C. physician endorsement to other states, \$40;
- D. physician emeritus license, \$50;
- E. physician temporary licenses, \$60;
- F. physician late fee, \$60;
- G. physician assistant application fee, \$120;
- H. physician assistant annual registration (prescribing), \$135;
- I. physician assistant annual registration (nonprescribing), \$115;
- J. physician assistant temporary registration, \$115;
- K. physician assistant temporary permit, \$60;
- L. physician assistant locum tenens permit, \$25;
- M. physician assistant late fee, \$50;
- N. acupuncture temporary permit, \$60;
- O. acupuncture inactive status fee, \$50;
- P. respiratory care annual registration, \$90;
- Q. respiratory care application fee, \$100;
- R. respiratory care late fee, \$50;
- S. respiratory care inactive status, \$50;
- T. respiratory care temporary permit, \$60;
- U. respiratory care temporary registration, \$90;
- V. duplicate license or registration fee, \$20;
- W. certification letter, \$25;
- X. verification of status, \$10;
- Y. education or training program approval fee, \$100;
- Z. report creation and generation, \$60 per hour billed in quarter-hour increments with a quarter-hour minimum; and
- AA. examination administrative fee:
 - (1) half day, \$50; and
 - (2) full day, \$80.

The renewal cycle for physician assistants under items H and I begins July 1. The duration of the permit issued under item L is one year.

9530.6405 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 9530.6405 to 9530.6505, the following terms have the meanings given to them.

9530.6405 DEFINITIONS.

Subp. 1a. **Administration of medications.** "Administration of medications" means performing a task to provide medications to a client, and includes the following tasks, performed in the following order:

- A. checking the client's medication record;
- B. preparing the medication for administration;
- C. administering the medication to the client;
- D. documenting the administration, or the reason for not administering medications as prescribed; and
- E. reporting information to a licensed practitioner or a nurse regarding problems with the administration of the medication or the client's refusal to take the medication.

9530.6405 DEFINITIONS.

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Subp. 2. **Adolescent.** "Adolescent" means an individual under 18 years of age.

9530.6405 DEFINITIONS.

Subp. 3. **Alcohol and drug counselor.** "Alcohol and drug counselor" has the meaning given in Minnesota Statutes, section 148C.01, subdivision 2.

9530.6405 DEFINITIONS.

Subp. 4. **Applicant.** "Applicant" means an individual, corporation, partnership, voluntary association, controlling individual, or other organization that has applied for licensure under this chapter.

9530.6405 DEFINITIONS.

Subp. 5. **Capacity management system.** "Capacity management system" means a database operated by the Department of Human Services to compile and make information available to the public about the waiting list status and current admission capability of each program serving intravenous drug abusers.

9530.6405 DEFINITIONS.

Subp. 6. **Central registry.** "Central registry" means a database maintained by the department that collects identifying information from two or more programs about individuals applying for maintenance treatment or detoxification treatment for addiction to opiates for the purpose of avoiding an individual's concurrent enrollment in more than one program.

9530.6405 DEFINITIONS.

Subp. 7. **Chemical.** "Chemical" means alcohol, solvents, controlled substances as defined by Minnesota Statutes, section 152.01, subdivision 4, and other mood altering substances.

9530.6405 DEFINITIONS.

Subp. 7a. **Chemical dependency treatment.** "Chemical dependency treatment" means treatment of a substance use disorder, including the process of assessment of a client's needs, development of planned interventions or services to address those needs, provision of services, facilitation of services provided by other service providers, and reassessment by a qualified professional. The goal of treatment is to assist or support the client's efforts to recover from substance use disorder.

9530.6405 DEFINITIONS.

Subp. 8. **Client.** "Client" means an individual accepted by a license holder for assessment or treatment of a substance use disorder. An individual remains a client until the license holder no longer provides or plans to provide the individual with treatment services.

9530.6405 DEFINITIONS.

Subp. 9. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designee.

9530.6405 DEFINITIONS.

Subp. 10. **Co-occurring or co-occurring client.** "Co-occurring" or "co-occurring client" means a diagnosis that indicates a client suffers from a substance use disorder and a mental health problem.

9530.6405 DEFINITIONS.

Subp. 11. **Department.** "Department" means the Department of Human Services.

9530.6405 DEFINITIONS.

Subp. 12. **Direct client contact.** "Direct client contact" has the meaning given for "direct contact" in Minnesota Statutes, section 245C.02, subdivision 11.

9530.6405 DEFINITIONS.

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Subp. 13. **License.** "License" means a certificate issued by the commissioner authorizing the license holder to provide a specific program for a specified period of time in accordance with the terms of the license and the rules of the commissioner.

9530.6405 DEFINITIONS.

Subp. 14. **License holder.** "License holder" means an individual, corporation, partnership, voluntary organization, or other organization that is legally responsible for the operation of the program, has been granted a license by the commissioner under this chapter, and is a controlling individual.

9530.6405 DEFINITIONS.

Subp. 14a. **Licensed practitioner.** "Licensed practitioner" means a person who is authorized to prescribe as defined in Minnesota Statutes, section 151.01, subdivision 23.

9530.6405 DEFINITIONS.

Subp. 15. **Licensed professional in private practice.** "Licensed professional in private practice" means an individual who meets the following criteria:

A. is licensed under Minnesota Statutes, chapter 148C, or is exempt from licensure under that chapter but is otherwise licensed to provide alcohol and drug counseling services;

B. practices solely within the permissible scope of the individual's license as defined in the law authorizing licensure; and

C. does not affiliate with other licensed or unlicensed professionals for the purpose of providing alcohol and drug counseling services. Affiliation does not include conferring with other professionals or making client referrals.

9530.6405 DEFINITIONS.

Subp. 15a. **Nurse.** "Nurse" means a person licensed and currently registered to practice professional or practical nursing as defined in Minnesota Statutes, section 148.171, subdivisions 14 and 15.

9530.6405 DEFINITIONS.

Subp. 16. **Paraprofessional.** "Paraprofessional" means an employee, agent, or independent contractor of the license holder who performs tasks in support of the provision of treatment services. Paraprofessionals may be referred to by a variety of titles including technician, case aide, or counselor assistant. An individual may not be a paraprofessional employed by the license holder if the individual is a client of the license holder.

9530.6405 DEFINITIONS.

Subp. 17. **Program serving intravenous drug abusers.** "Program serving intravenous drug abusers" means a program whose primary purpose is providing agonist medication-assisted therapy to clients who are narcotic dependent, regardless of whether the client's narcotic use was intravenous or by other means.

9530.6405 DEFINITIONS.

Subp. 17a. **Student intern.** "Student intern" means a person who is enrolled in an alcohol and drug counselor education program at an accredited school or educational program and is earning a minimum of nine semester credits per calendar year toward the completion of an associate's, bachelor's, master's, or doctorate degree requirements. Degree requirements must include an additional 18 semester credits or 270 hours of alcohol and drug counseling related course work and 440 hours of practicum.

9530.6405 DEFINITIONS.

Subp. 17b. **Substance.** "Substance" means a "chemical" as defined in subpart 7.

9530.6405 DEFINITIONS.

Subp. 17c. **Substance use disorder.** "Substance use disorder" means a pattern of substance use as defined in the Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM), et seq. The DSM-IV-TR is incorporated by reference. The DSM was published by the American

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Psychiatric Association in 1994, in Washington D.C., and is not subject to frequent change. The DSM-IV-TR is available through the Minitex interlibrary loan system.

9530.6405 DEFINITIONS.

Subp. 18. **Target population.** "Target population" means individuals experiencing problems with a substance use disorder having the specified characteristics that a license holder proposes to serve.

9530.6405 DEFINITIONS.

Subp. 20. **Treatment director.** "Treatment director" means an individual who meets the qualifications specified under part 9530.6450, subparts 1 and 3, and is designated by the license holder to be responsible for all aspects of the delivery of treatment services.

9530.6405 DEFINITIONS.

Subp. 21. **Treatment service.** "Treatment service" means a therapeutic intervention or series of interventions.

9530.6410 APPLICABILITY.

Subpart 1. **Applicability.** Except as provided in subparts 2 and 3, no person, corporation, partnership, voluntary association, controlling individual, or other organization may provide chemical dependency treatment services to an individual who has a substance use disorder unless licensed by the commissioner.

Subp. 2. **Activities exempt from license requirement.** Parts 9530.6405 to 9530.6505 do not apply to organizations whose primary functions are information, referral, diagnosis, case management, and assessment for the purposes of placement, education, support group services, or self-help programs. Parts 9530.6405 to 9530.6505 do not apply to the activities of licensed professionals in private practice which are not paid for by the consolidated chemical dependency treatment fund.

Subp. 3. **Certain hospitals excluded from license requirement.** Parts 9530.6405 to 9530.6505 do not apply to chemical dependency treatment provided by hospitals licensed under Minnesota Statutes, chapter 62J, or under Minnesota Statutes, sections 144.50 to 144.56, unless the hospital accepts funds for chemical dependency treatment under the consolidated chemical dependency treatment fund under Minnesota Statutes, chapter 254B, medical assistance under Minnesota Statutes, chapter 256B, MinnesotaCare or health care cost containment under Minnesota Statutes, chapter 256L, or general assistance medical care under Minnesota Statutes, chapter 256D.

Subp. 4. **Applicability of chapter 2960.** Beginning July 1, 2005, residential adolescent chemical dependency treatment programs must be licensed according to chapter 2960.

9530.6415 LICENSING REQUIREMENTS.

Subpart 1. **General application and license requirements.** An applicant for a license to provide treatment must comply with the general requirements in Minnesota Statutes, chapters 245A and 245C, and Minnesota Statutes, sections 626.556 and 626.557.

Subp. 2. **Contents of application.** Prior to issuance of a license, an applicant must submit, on forms provided by the commissioner, any documents the commissioner requires to demonstrate the following:

- A. compliance with parts 9530.6405 to 9530.6505;
- B. compliance with applicable building, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or documentation that a waiver has been granted. The granting of a waiver does not constitute modification of any requirement of parts 9530.6405 to 9530.6505;
- C. completion of an assessment of need for a new or expanded program according to part 9530.6800; and
- D. insurance coverage, including bonding, sufficient to cover all client funds, property, and interests.

Subp. 3. **Changes in license terms.**

A. A license holder must notify the commissioner before one of the following occurs and the commissioner must determine the need for a new license:

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- (1) a change in the Department of Health's licensure of the program;
- (2) a change in whether the license holder provides services specified in parts 9530.6485 to 9530.6505;
- (3) a change in location; or
- (4) a change in capacity if the license holder meets the requirements of part 9530.6505.

B. A license holder must notify the commissioner and must apply for a new license if there is a change in program ownership.

9530.6420 INITIAL SERVICES PLAN.

The license holder must complete an initial services plan during or immediately following the intake interview. The plan must address the client's immediate health and safety concerns, identify the issues to be addressed in the first treatment sessions, and make treatment suggestions for the client during the time between intake and completion of the treatment plan. The initial services plan must include a determination whether a client is a vulnerable adult as defined in Minnesota Statutes, section 626.5572, subdivision 21. All adult clients of a residential program are vulnerable adults. An individual abuse prevention plan, according to Minnesota Statutes, sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14, paragraph (b), is required for all clients who meet the definition of "vulnerable adult."

9530.6422 COMPREHENSIVE ASSESSMENT.

Subpart 1. **Comprehensive assessment of substance use disorder.** A comprehensive assessment of the client's substance use disorder must be coordinated by an alcohol and drug counselor and completed within three calendar days after service initiation for a residential program or three sessions of the client's initiation to services for all other programs. The alcohol and drug counselor may rely on current information provided by a referring agency or other sources as a supplement when information is available. Information gathered more than 45 days before the date of admission is not current. If the comprehensive assessment cannot be completed in the time specified, the treatment plan must indicate how and when it will be completed. The assessment must include sufficient information to complete the assessment summary according to subpart 2 and part 9530.6425. The comprehensive assessment must include information about the client's problems that relate to chemical use and personal strengths that support recovery, including:

- A. age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;
- B. circumstances of service initiation;
- C. previous attempts at treatment for chemical use or dependency, compulsive gambling, or mental illness;
- D. chemical use history including amounts and types of chemicals used, frequency and duration of use, periods of abstinence, and circumstances of relapse, if any. For each chemical used within the previous 30 days, the information must include the date and time of the most recent use and any previous experience with withdrawal;
- E. specific problem behaviors exhibited by the client when under the influence of chemicals;
- F. current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse, or dependency among family members and significant others;
- G. physical concerns or diagnoses, the severity of the concerns, and whether or not the concerns are being addressed by a health care professional;
- H. mental health history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medication needed to maintain stability;
- I. arrests and legal interventions related to chemical use;
- J. ability to function appropriately in work and educational settings;
- K. ability to understand written treatment materials, including rules and client rights;
- L. risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases;
- M. social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use;

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N. whether the client is pregnant and if so, the health of the unborn child and current involvement in prenatal care; and

O. whether the client recognizes problems related to substance use and is willing to follow treatment recommendations.

Subp. 2. **Assessment summary.** An alcohol and drug counselor must prepare an assessment summary within three calendar days for a residential program or within three treatment sessions of service initiation. The narrative summary of the comprehensive assessment results must meet the requirements of items A and B:

A. An assessment summary must be prepared by an alcohol and drug counselor and include:

- (1) a risk description according to part 9530.6622 for each dimension listed in item B;
- (2) narrative supporting the risk descriptions; and
- (3) a determination of whether the client meets the DSM criteria for a person with a substance use disorder.

B. Contain information relevant to treatment planning and recorded in the dimensions in subitems (1) to (6):

(1) Dimension 1, acute intoxication/withdrawal potential. The license holder must consider the client's ability to cope with withdrawal symptoms and current state of intoxication.

(2) Dimension 2, biomedical conditions and complications. The license holder must consider the degree to which any physical disorder would interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child if the client is pregnant.

(3) Dimension 3, emotional, behavioral, and cognitive conditions and complications. The license holder must determine the degree to which any condition or complications are likely to interfere with treatment for substance abuse or with functioning in significant life areas and the likelihood of risk of harm to self or others.

(4) Dimension 4, readiness for change. The license holder must also consider the amount of support and encouragement necessary to keep the client involved in treatment.

(5) Dimension 5, relapse, continued use, and continued problem potential. The license holder must consider the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.

(6) Dimension 6, recovery environment. The license holder must consider the degree to which key areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

9530.6425 INDIVIDUAL TREATMENT PLANS.

Subpart 1. **General.** Individual treatment plans for clients in treatment must be completed within seven calendar days of completion of the assessment summary. Treatment plans must continually be updated, based on new information gathered about the client's condition and on whether planned treatment interventions have had the intended effect. Treatment planning must include ongoing assessment in each of the six dimensions according to part 9530.6422, subpart 2. The plan must provide for the involvement of the client's family and those people selected by the client as being important to the success of the treatment experience at the earliest opportunity, consistent with the client's treatment needs and written consent. The plan must be developed after completion of the comprehensive assessment and is subject to amendment until services to the client are terminated. The client must have an opportunity to have active, direct involvement in selecting the anticipated outcomes of the treatment process and in developing the individual treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor. The individual treatment plan may be a continuation of the initial services plan required in part 9530.6420.

Subp. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and address each problem identified in the assessment summary, and include:

A. specific methods to be used to address identified problems, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

B. resources to which the client is being referred for problems when problems are to be addressed concurrently by another provider; and

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C. goals the client must reach to complete treatment and have services terminated.

Subp. 3. Progress notes and plan review.

A. Progress notes must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff person providing the service. The note must reference the treatment plan. Progress notes must be recorded and address each of the six dimensions listed in part 9530.6422, subpart 2, item B. Progress notes must:

- (1) be entered immediately following any significant event. Significant events include those events which have an impact on the client's relationship with other clients, staff, the client's family, or the client's treatment plan;
- (2) indicate the type and amount of each treatment service the client has received;
- (3) include monitoring of any physical and mental health problems and the participation of others in the treatment plan;
- (4) document the participation of others; and
- (5) document that the client has been notified of each treatment plan change and that the client either does or does not agree with the change.

B. Treatment plan review must:

- (1) occur weekly or after each treatment service, whichever is less frequent;
- (2) address each goal in the treatment plan that has been worked on since the last review;
- (3) address whether the strategies to address the goals are effective, and if not, must include changes to the treatment plan; and
- (4) include a review and evaluation of the individual abuse prevention plan according to Minnesota Statutes, section 245A.65.

C. All entries in a client's record must be legible, signed, and dated. Late entries must be clearly labeled "late entry." Corrections to an entry must be made in a way in which the original entry can still be read.

Subp. 3a. Documentation. Progress notes and plan review do not require separate documentation if the information in the client file meets the requirements of subpart 3, items A and B.

Subp. 4. Summary at termination of services. An alcohol and drug counselor must write a discharge summary for each client. The summary must be completed within five days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier.

A. The summary at termination of services must be recorded in the six dimensions listed in part 9530.6422, subpart 2, item B, and include the following information:

- (1) client's problems, strengths, and needs while participating in treatment, including services provided;
- (2) client's progress toward achieving each of the goals identified in the individual treatment plan;
- (3) reasons for and circumstances of service termination; and
- (4) risk description according to part 9530.6622.

B. For clients who successfully complete treatment, the summary must also include:

- (1) living arrangements upon discharge;
- (2) continuing care recommendations, including referrals made with specific attention to continuity of care for mental health problems, as needed;
- (3) service termination diagnosis; and
- (4) client's prognosis.

9530.6430 TREATMENT SERVICES.

Subpart 1. Treatment services offered by license holder.

A. A license holder must offer the following treatment services unless clinically inappropriate and the justifying clinical rationale is documented:

- (1) individual and group counseling to help the client identify and address problems related to chemical use and develop strategies to avoid inappropriate chemical use after discharge;

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(2) client education strategies to avoid inappropriate chemical use and health problems related to chemical use and the necessary changes in lifestyle to regain and maintain health. Client education must include information concerning the human immunodeficiency virus, according to Minnesota Statutes, section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, hepatitis, and tuberculosis;

(3) transition services to help the client integrate gains made during treatment into daily living and to reduce reliance on the license holder's staff for support;

(4) services to address issues related to co-occurring mental illness, including education for clients on basic symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while working on recovery from substance use disorder. Groups must address co-occurring mental illness issues, as needed. When treatment for mental health problems is indicated, it is integrated into the client's treatment plan; and

(5) service coordination to help the client obtain the services and to support the client's need to establish a lifestyle free of the harmful effects of substance use disorder.

B. Treatment services provided to individual clients must be provided according to the individual treatment plan and must address cultural differences and special needs of all clients.

Subp. 2. **Additional treatment services.** A license holder may provide or arrange the following additional treatment services as a part of the individual treatment plan:

A. relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

B. therapeutic recreation to provide the client with an opportunity to participate in recreational activities without the use of mood-altering chemicals and to learn to plan and select leisure activities that do not involve the inappropriate use of chemicals;

C. stress management and physical well-being to help the client reach and maintain an acceptable level of health, physical fitness, and well-being;

D. living skills development to help the client learn basic skills necessary for independent living;

E. employment or educational services to help the client become financially independent;

F. socialization skills development to help the client live and interact with others in a positive and productive manner; and

G. room, board, and supervision provided at the treatment site to give the client a safe and appropriate environment in which to gain and practice new skills.

Subp. 3. **Counselors to provide treatment services.** Treatment services, including therapeutic recreation, must be provided by alcohol and drug counselors qualified according to part 9530.6450, unless the individual providing the service is specifically qualified according to the accepted standards of that profession. Therapeutic recreation does not include planned leisure activities.

Subp. 4. **Location of service provision.** A client of a license holder may only receive services at any of the license holder's licensed locations or at the client's home, except that services under subpart 1, item A, subitems (3) and (5), and subpart 2, items B and E, may be provided in another suitable location.

9530.6435 MEDICAL SERVICES.

Subpart 1. **Health care services description.** An applicant or license holder must maintain a complete description of the health care services, nursing services, dietary services, and emergency physician services offered by the license holder.

Subp. 1a. **Procedures.** The applicant or license holder must have written procedures for obtaining medical interventions when needed for a client, that are approved in writing by a physician who is licensed under Minnesota Statutes, chapter 147, unless:

A. the license holder does not provide services under part 9530.6505; and

B. all medical interventions are referred to 911, the emergency telephone number, or the client's physician.

Subp. 2. **Consultation services.** The license holder must have access to and document the availability of a licensed mental health professional to provide diagnostic assessment and treatment planning assistance.

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Subp. 3. **Administration of medications and assistance with self-medication.** A license holder must meet the requirements in items A and B if services include medication administration.

A. A staff member, other than a licensed practitioner or nurse, who is delegated by a licensed practitioner or a registered nurse the task of administration of medication or assistance with self-medication must:

(1) document that the staff member has successfully completed a medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution. Completion of the course must be documented in writing and placed in the staff member's personnel file; or

(2) be trained according to a formalized training program which is taught by a registered nurse and offered by the license holder. Completion of the course must be documented in writing and placed in the staff member's personnel records; or

(3) demonstrate to a registered nurse competency to perform the delegated activity.

B. A registered nurse must be employed or contracted to develop the policies and procedures for medication administration or assistance with self-administration of medication or both. A registered nurse must provide supervision as defined in part 6321.0100. The registered nurse supervision must include monthly on-site supervision or more often as warranted by client health needs. The policies and procedures must include:

(1) a provision that delegations of administration of medication are limited to administration of those medications which are oral, suppository, eye drops, ear drops, inhalant, or topical;

(2) a provision that each client's file must include documentation indicating whether staff will be administering medication or the client will be doing self-administration or a combination of both;

(3) a provision that clients may carry emergency medication such as nitroglycerin as instructed by their physician;

(4) a provision for medication to be self-administered when a client is scheduled not to be at the facility;

(5) a provision that if medication is to be self-administered at a time when the client is present in the facility, medication will be self-administered under observation of a trained staff person;

(6) a provision that when a license holder serves clients who are parents with children, the parent may only administer medication to the child under staff supervision;

(7) requirements for recording the client's use of medication, including staff signatures with date and time;

(8) guidelines for when to inform a registered nurse of problems with self-administration, including failure to administer, client refusal of a medication, adverse reactions, or errors; and

(9) procedures for acceptance, documentation, and implementation of prescriptions, whether written, verbal, telephonic, or electronic.

Subp. 4. **Control of drugs.** A license holder must have in place and implement written policies and procedures developed by a registered nurse that contains the following provisions:

A. a requirement that all drugs must be stored in a locked compartment. Schedule II drugs, as defined by Minnesota Statutes, section 152.02, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

B. a system which accounts for all scheduled drugs each shift;

C. a procedure for recording the client's use of medication, including the signature of the administrator of the medication with the time and date;

D. a procedure for destruction of discontinued, outdated, or deteriorated medications;

E. a statement that only authorized personnel are permitted to have access to the keys to the locked drug compartments; and

F. a statement that no legend drug supply for one client will be given to another client.

9530.6440 CLIENT RECORDS.

Subpart 1. **Client records required.** A license holder must maintain a file of current client records on the premises where the treatment services are provided or coordinated. The content and format of client records must be uniform and entries in each case must be signed and dated by

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the staff member making the entry. Client records must be protected against loss, tampering, or unauthorized disclosure in compliance with Minnesota Statutes, section 254A.09, Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164, and, if applicable, Minnesota Statutes, chapter 13.

Subp. 2. **Records retention.** Records of discharged clients must be retained by a license holder for seven years. License holders that cease to provide treatment services must retain client records for seven years from the date of facility closure and must notify the commissioner of the location of the records and the name of a person responsible for maintaining the records.

Subp. 3. **Client records, contents.** Client records must contain the following:

- A. documentation that the client was given information on client rights, responsibilities, grievance procedures, tuberculosis, and HIV, and that the client was provided an orientation to the program abuse prevention plan as required under Minnesota Statutes, section 245A.65, subdivision 2, paragraph (a), clause (4);
- B. an initial services plan completed according to part 9530.6420;
- C. a comprehensive assessment completed according to part 9530.6422;
- D. an assessment summary completed according to part 9530.6422, subpart 2;
- E. an individual abuse prevention plan that complies with Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;
- F. an individual treatment plan, as required under part 9530.6425, subparts 1 and 2;
- G. progress notes, as required in part 9530.6425, subpart 3; and
- H. a summary of termination of services, written according to part 9530.6425, subpart 4.

Subp. 4. **Electronic records.** A license holder who intends to use electronic record keeping or electronic signatures to comply with parts 9530.6405 to 9530.6505 must first obtain written permission from the commissioner. The commissioner must grant permission after the license holder provides documentation demonstrating the license holder's use of a system for ensuring security of electronic records. Use of electronic record keeping or electronic signatures does not alter the license holder's obligations under state or federal law, regulation, or rule.

9530.6445 STAFFING REQUIREMENTS.

Subpart 1. **Treatment director required.** A license holder must have a treatment director.

Subp. 2. **Alcohol and drug counselor supervisor requirements.** A license holder must employ an alcohol and drug counselor supervisor who meets the requirements under part 9530.6450, subpart 4. An individual may be simultaneously employed as a treatment director, alcohol and drug counselor supervisor, and an alcohol and drug counselor if the individual meets the qualifications for each position. If an alcohol and drug counselor is simultaneously an alcohol and drug counselor supervisor or treatment director, that individual must be considered a 0.5 full-time equivalent alcohol and drug counselor for purposes of meeting the staffing requirements under subpart 4.

Subp. 3. **Responsible staff person.** A treatment director must designate a staff member who, when present in the facility, is responsible for the delivery of treatment services. A license holder must have a designated staff person during all hours of operation. A license holder providing room and board and treatment at the same site must have a responsible staff person on duty 24 hours a day. The designated staff person must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 4. **Staffing requirements.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group shall not exceed an average of 16 clients during any 30 consecutive calendar days. It is the responsibility of the license holder to determine an acceptable group size based on the client's needs. A counselor in a program treating intravenous drug abusers must not supervise more than 50 clients. The license holder must maintain a record that documents compliance with this subpart.

Subp. 5. **Medical emergencies.** When clients are present, a license holder must have at least one staff person on the premises who has a current American Red Cross standard first aid certificate or an equivalent certificate and at least one staff person on the premises who has a current American Red Cross community, American Heart Association, or equivalent CPR certificate. A single staff person with both certifications satisfies this requirement.

9530.6450 STAFF QUALIFICATIONS.

Subpart 1. **Qualifications of all staff members with direct client contact.** All staff members who have direct client contact must be at least 18 years of age. At the time of hiring, all staff members must meet the qualifications in item A or B. A chemical use problem for purposes of this subpart is a problem listed by the license holder in the personnel policies and procedures according to part 9530.6460, subpart 1, item E.

A. Treatment directors, supervisors, nurses, counselors, and other professionals must be free of chemical use problems for at least the two years immediately preceding their hiring and must sign a statement attesting to that fact.

B. Paraprofessionals and all other staff members with direct client contact must be free of chemical use problems for at least one year immediately preceding their hiring and must sign a statement attesting to that fact.

Subp. 2. **Employment; prohibition on chemical use problems.** Staff members with direct client contact must be free from chemical use problems as a condition of employment, but are not required to sign additional statements. Staff members with direct client contact who are not free from chemical use problems must be removed from any responsibilities that include direct client contact for the time period specified in subpart 1. The time period begins to run on the date the employee begins receiving treatment services or the date of the last incident as described in the list developed according to part 9530.6460, subpart 1, item E.

Subp. 3. **Treatment director qualifications.** In addition to meeting the requirements of subpart 1, a treatment director must know and understand the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, chapter 245A, and sections 626.556, 626.557, and 626.5572. A treatment director must:

A. have at least one year of work experience in direct service to individuals with chemical use problems or one year of work experience in the management or administration of direct service to individuals with chemical use problems; and

B. have a baccalaureate degree or three years of work experience in administration or personnel supervision in human services.

Subp. 4. **Alcohol and drug counselor supervisor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor supervisor must meet the following qualifications:

A. the individual is competent in the areas specified in subpart 5;

B. the individual has three or more years of experience providing individual and group counseling to chemically dependent clients except that, prior to January 1, 2005, an individual employed in a program formerly licensed under parts 9530.5000 to 9530.6400 is required to have one or more years experience; and

C. the individual knows and understands the implications of parts 9530.6405 to 9530.6505 and Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572.

Subp. 5. **Alcohol and drug counselor qualifications.** In addition to meeting the requirements of subpart 1, an alcohol and drug counselor must be either licensed or exempt from licensure under Minnesota Statutes, chapter 148C. An alcohol and drug counselor must document competence in screening for and working with clients with mental health problems, through education, training, and experience.

A. Alcohol and drug counselors licensed under Minnesota Statutes, chapter 148C, must comply with rules adopted under Minnesota Statutes, chapter 148C.

B. Counselors exempt under Minnesota Statutes, chapter 148C, must be competent, as evidenced by one of the following:

(1) completion of at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, or licensure as a registered nurse; successful completion of a minimum of 120 hours of classroom instruction in which each of the core functions listed in Minnesota Statutes, chapter 148C, is covered; and successful completion of 440 hours of supervised experience as an alcohol and drug counselor, either as a student or as a staff member;

(2) completion of 270 hours of alcohol and drug counselor training in which each of the core functions listed in Minnesota Statutes, chapter 148C, is covered, and successful completion of 880 hours of supervised experience as an alcohol and drug counselor, either as a student, or as a staff member;

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(3) current certification as an alcohol and drug counselor or alcohol and drug counselor reciprocal, through the evaluation process established by the International Certification and Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1993. The manual is incorporated by reference. It is available at the State Law Library, Judicial Center, 25 Reverend Dr. Martin Luther King Jr. Blvd., St. Paul, Minnesota 55155;

(4) completion of a bachelor's degree including 480 hours of alcohol and drug counseling education from an accredited school or educational program and 880 hours of alcohol and drug counseling practicum; or

(5) employment in a program formerly licensed under parts 9530.5000 to 9530.6400 and successful completion of 6,000 hours of supervised work experience in a licensed program as an alcohol and drug counselor prior to January 1, 2005.

Subp. 6. **Paraprofessional qualifications and duties.** A paraprofessional must comply with subpart 1 and have knowledge of client rights, outlined in Minnesota Statutes, section 148F.165, and of staff responsibilities. A paraprofessional may not admit, transfer, or discharge clients but may be the person responsible for the delivery of treatment services as required in part 9530.6445, subpart 3.

Subp. 7. **Volunteers.** Volunteers may provide treatment services when they are supervised and can be seen or heard by a staff member meeting the criteria in subpart 4 or 5, but may not practice alcohol and drug counseling unless qualified under subpart 5.

Subp. 8. **Student interns.** A qualified staff person must supervise and be responsible for all treatment services performed by student interns and must review and sign all assessments, progress notes, and treatment plans prepared by the intern. Student interns must meet the requirements in subpart 1, item A, and receive the orientation and training required in part 9530.6460, subpart 1, item G, and subpart 2.

Subp. 9. **Individuals with temporary permit.** Individuals with a temporary permit from the Board of Behavioral Health and Therapy may provide chemical dependency treatment services under the conditions in either item A or B.

A. The individual is supervised by a licensed alcohol and drug counselor assigned by the license holder. The licensed alcohol and drug counselor must document the amount and type of supervision at least weekly. The supervision must relate to clinical practices. One licensed alcohol and drug counselor may not supervise more than three individuals with temporary permits, according to Minnesota Statutes, section 148C.01, subdivision 12a.

B. The individual is supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of Minnesota Statutes, section 148C.044, subdivision 4.

9530.6455 PROVIDER POLICIES AND PROCEDURES.

License holders must develop a written policy and procedures manual indexed according to Minnesota Statutes, section 245A.04, subdivision 14, paragraph (c), so that staff may have immediate access to all policies and procedures and so that consumers of the services and other authorized parties may have access to all policies and procedures. The manual must contain the following materials:

A. assessment and treatment planning policies, which include screening for mental health concerns, and the inclusion of treatment objectives related to identified mental health concerns in the client's treatment plan;

B. policies and procedures regarding HIV that comply with Minnesota Statutes, section 245A.19;

C. the methods and resources used by the license holder to provide information on tuberculosis and tuberculosis screening to all clients and to report known cases of tuberculosis infection according to Minnesota Statutes, section 144.4804;

D. personnel policies that comply with part 9530.6460;

E. policies and procedures that protect client rights as required under part 9530.6470;

F. a medical services plan that complies with part 9530.6435;

G. emergency procedures that comply with part 9530.6475;

H. policies and procedures for maintaining client records under part 9530.6440;

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I. procedures for reporting the maltreatment of minors under Minnesota Statutes, section 626.556, and vulnerable adults under Minnesota Statutes, sections 245A.65, 626.557, and 626.5572;

J. a description of treatment services including the amount and type of client services provided;

K. the methods used to achieve desired client outcomes; and

L. the hours of operation and target population served.

9530.6460 PERSONNEL POLICIES AND PROCEDURES.

Subpart 1. **Policy requirements.** License holders must have written personnel policies and must make them available to each staff member. The policies must:

A. assure that staff member retention, promotion, job assignment, or pay are not affected by a good faith communication between a staff member and the Department of Health, the Department of Human Services, the ombudsman for mental health and developmental disabilities, law enforcement, or local agencies for the investigation of complaints regarding a client's rights, health, or safety;

B. contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, and qualifications;

C. provide for job performance evaluations based on standards of job performance to be conducted on a regular and continuing basis, including a written annual review;

D. describe behavior that constitutes grounds for disciplinary action, suspension or dismissal, including policies that address chemical use problems and meet the requirements of part 9530.6450, subpart 1, policies prohibiting personal involvement with clients in violation of Minnesota Statutes, chapter 604, and policies prohibiting client abuse as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.557, and 626.5572;

E. list behaviors or incidents that are considered chemical use problems. The list must include:

(1) receiving treatment for chemical use within the period specified for the position in the staff qualification requirements;

(2) chemical use that has a negative impact on the staff member's job performance;

(3) chemical use that affects the credibility of treatment services with clients, referral sources, or other members of the community; and

(4) symptoms of intoxication or withdrawal on the job;

F. include a chart or description of the organizational structure indicating lines of authority and responsibilities;

G. include orientation within 24 working hours of starting for all new staff based on a written plan that, at a minimum, must provide for training related to the specific job functions for which the staff member was hired, policies and procedures, client confidentiality, the human immunodeficiency virus minimum standards, and client needs; and

H. policies outlining the license holder's response to staff members with behavior problems that interfere with the provision of treatment services.

Subp. 2. **Staff development.** A license holder must ensure that each staff person has the training required in items A to E.

A. All staff must be trained every two years in client confidentiality rules and regulations and client ethical boundaries.

B. All staff must be trained every two years in emergency procedures and client rights as specified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03.

C. All staff with direct client contact must be trained every year on mandatory reporting as specified under Minnesota Statutes, sections 245A.65, 626.556, 626.5561, 626.5563, 626.557, and 626.5572, including specific training covering the facility's policies concerning obtaining client releases of information.

D. All staff with direct client contact must receive training upon hiring and annually thereafter on the human immunodeficiency virus minimum standards according to Minnesota Statutes, section 245A.19.

E. Treatment directors, supervisors, nurses, and counselors must obtain 12 hours of training in co-occurring mental health problems and substance use disorder that includes competencies related to philosophy, screening, assessment, diagnosis and treatment planning,

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documentation, programming, medication, collaboration, mental health consultation, and discharge planning. Staff employed by a license holder on the date this rule is adopted must obtain the training within 12 months of the date of adoption. New staff who have not obtained such training must obtain it within 12 months of the date this rule is adopted or within six months of hire, whichever is later. Staff may request, and the license holder may grant credit for, relevant training obtained prior to January 1, 2005.

Subp. 3. **Personnel files.** The license holder must maintain a separate personnel file for each staff member. At a minimum, the personnel file must be maintained to meet the requirements under parts 9530.6405 to 9530.6505 and contain the following:

A. a completed application for employment signed by the staff member and containing the staff member's qualifications for employment;

B. documentation related to the applicant's background study data, as defined in Minnesota Statutes, chapter 245C;

C. for staff members who will be providing psychotherapy services, employer names and addresses for the past five years for which the staff member provided psychotherapy services, and documentation of an inquiry made to these former employers regarding substantiated sexual contact with a client as required by Minnesota Statutes, chapter 604;

D. documentation of completed orientation and training;

E. documentation demonstrating compliance with parts 9530.6450 and 9530.6485, subpart 2; and

F. documentation demonstrating compliance with part 9530.6435, subpart 3, for staff members who administer medications.

9530.6465 SERVICE INITIATION AND TERMINATION POLICIES.

Subpart 1. **Service initiation policy.** A license holder must have a written service initiation policy containing service initiation preferences which comply with this rule and Code of Federal Regulations, title 45, part 96.131, and specific service initiation criteria. The license holder must not initiate services for individuals who do not meet the service initiation criteria. The service initiation criteria must be either posted in the area of the facility where services for clients are initiated, or given to all interested persons upon request. Titles of all staff members authorized to initiate services for clients must be listed in the services initiation and termination policies. A license holder that serves intravenous drug abusers must have a written policy that provides service initiation preference as required by Code of Federal Regulations, title 45, part 96.131.

Subp. 2. **License holder responsibilities; terminating or denying services.** A license holder has specific responsibilities when terminating services or denying treatment service initiation to clients for reasons of health, behavior, or criminal activity.

A. The license holder must have and comply with a written protocol for assisting clients in need of care not provided by the license holder, and for clients who pose a substantial likelihood of harm to themselves or others, if the behavior is beyond the behavior management capabilities of the staff. All service terminations and denials of service initiation which pose an immediate threat to the health of any individual or require immediate medical intervention must be referred to a medical facility capable of admitting the individual.

B. All service termination policies and denials of service initiation that involve the commission of a crime against a license holder's staff member or on a license holder's property, as provided under Code of Federal Regulations, title 42, section 2.12(c)(5), and Code of Federal Regulations, title 45, parts 160 to 164, must be reported to a law enforcement agency with proper jurisdiction.

Subp. 3. **Service termination and transfer policies.** A license holder must have a written policy specifying the conditions under which clients must be discharged. The policy must include:

A. procedures for individuals whose services have been terminated under subpart 2;

B. a description of client behavior that constitutes reason for a staff-requested service termination and a process for providing this information to clients;

C. procedures consistent with Minnesota Statutes, section 253B.16, subdivision 2, that staff must follow when a client admitted under Minnesota Statutes, chapter 253B, is to have services terminated;

D. procedures staff must follow when a client leaves against staff or medical advice and when the client may be dangerous to self or others;

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E. procedures for communicating staff-approved service termination criteria to clients, including the expectations in the client's individual treatment plan according to part 9530.6425; and

F. titles of staff members authorized to terminate client services must be listed in the service initiation and termination policies.

9530.6470 POLICIES AND PROCEDURES THAT PROTECT CLIENT RIGHTS.

Subpart 1. **Client rights; explanation.** Clients have the rights identified in Minnesota Statutes, sections 144.651, 148F.165, and 253B.03, as applicable. The license holder must give each client upon service initiation a written statement of client's rights and responsibilities. Staff must review the statement with clients at that time.

Subp. 2. **Grievance procedure.** Upon service initiation, the license holder must explain the grievance procedure to the client or their representative. The grievance procedure must be posted in a place visible to clients, and made available upon a client's request. The grievance procedure must also be made available to former clients upon request. The grievance procedure must require that:

A. staff help the client develop and process a grievance;

B. telephone numbers and addresses of the Department of Human Services, licensing division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Minnesota Department of Health, Office of Alcohol and Drug Counselor Licensing Program, and Office of Health Facilities Complaints; when applicable, be made available to clients; and

C. a license holder be obligated to respond to the client's grievance within three days of a staff member's receipt of the grievance, and the client be permitted to bring the grievance to the highest level of authority in the program if not resolved by other staff members.

Subp. 3. **Photographs of client.** All photographs, video tapes, and motion pictures of clients taken in the provision of treatment services are considered client records. Photographs for identification and recordings by video and audio tape for the purpose of enhancing either therapy or staff supervision may be required of clients, but may only be available for use as communications within a program. Clients must be informed when their actions are being recorded by camera or tape, and have the right to deny any taping or photography, except as authorized by this subpart.

9530.6475 BEHAVIORAL EMERGENCY PROCEDURES.

A. A license holder or applicant must have written procedures that staff must follow when responding to a client who exhibits behavior that is threatening to the safety of the client or others. The procedures must include:

(1) a plan designed to prevent the client from hurting themselves or others;

(2) contact information for emergency resources that staff must consult when a client's behavior cannot be controlled by the procedures established in the plan;

(3) types of procedures that may be used;

(4) circumstances under which emergency procedures may be used; and

(5) staff members authorized to implement emergency procedures.

B. Behavioral emergency procedures must not be used to enforce facility rules or for the convenience of staff. Behavioral emergency procedures must not be part of any client's treatment plan, or used at any time for any reason except in response to specific current behaviors that threaten the safety of the client or others. Behavioral emergency procedures may not include the use of seclusion or restraint.

9530.6480 EVALUATION.

Subpart 1. **Participation in drug and alcohol abuse normative evaluation system.** License holders must participate in the drug and alcohol abuse normative evaluation system by submitting information about each client to the commissioner in a format specified by the commissioner.

Subp. 2. **Commissioner requests.** A license holder must submit additional information requested by the commissioner that is necessary to meet statutory or federal funding requirements.

9530.6485 LICENSE HOLDERS SERVING ADOLESCENTS.

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Subpart 1. **License holders serving adolescents.** A residential treatment program that serves persons under 18 years of age must be licensed as a residential program for children in out-of-home placement by the department unless the license holder is exempt under Minnesota Statutes, section 245A.03, subdivision 2.

Subp. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in part 9530.6450, subparts 1 and 5, an alcohol and drug counselor providing treatment services to adolescents must have:

A. an additional 30 hours of classroom instruction or one three-credit semester college course in adolescent development. This training need only be completed one time; and

B. at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.

Subp. 3. **Staffing ratios.** At least 25 percent of a counselor's scheduled work hours must be allocated to indirect services, including documentation of client services, coordination of services with others, treatment team meetings, and other duties. A counseling group consisting entirely of adolescents must not exceed 16 clients. It is the responsibility of the license holder to determine an acceptable group size based on the needs of the clients.

Subp. 4. **Academic program requirements.** Clients who are required to attend school must be enrolled and attending an educational program that has been approved by the Minnesota Department of Education.

Subp. 5. **Program requirements.** In addition to the requirements specified in the client's treatment plan under part 9530.6425, programs serving adolescents must include the following:

- A. coordination with the school system to address the client's academic needs;
- B. when appropriate, a plan that addresses the client's leisure activities without chemical use; and
- C. a plan that addresses family involvement in the adolescent's treatment.

9530.6490 LICENSE HOLDERS SERVING CLIENTS WITH CHILDREN.

Subpart 1. **Health license requirements.** In addition to the requirements of parts 9530.6405 to 9530.6480, all license holders that offer supervision of children of clients are subject to the requirements of this part. License holders providing room and board for clients and their children must have an appropriate facility license from the Minnesota Department of Health.

Subp. 2. **Supervision of children defined.** "Supervision of children" means a caregiver is within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver can intervene to protect the health and safety of the child. For the school age child it means a caregiver is available to help and care for the child so that the child's health and safety is protected.

Subp. 3. **Policy and schedule required.** License holders must meet the following requirements:

A. license holders must have a policy and schedule delineating the times and circumstances under which the license holder is responsible for supervision of children in the program and when the child's parents are responsible for child supervision. The policy must explain how the program will communicate its policy about child supervision responsibility to the parents; and

B. license holders must have written procedures addressing the actions to be taken by staff if children are neglected or abused including while the children are under the supervision of their parents.

Subp. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of children, the license holder must meet the following standards:

- A. child and adult ratios in part 9502.0367;
- B. day care training in Minnesota Statutes, section 245A.50;
- C. behavior guidance in part 9502.0395;
- D. activities and equipment in part 9502.0415;
- E. physical environment in part 9502.0425; and
- F. water, food, and nutrition in part 9502.0445, unless the license holder has a license from the Minnesota Department of Health.

9530.6495 LICENSE HOLDERS SERVING PERSONS WITH SUBSTANCE USE AND MENTAL HEALTH DISORDERS.

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In addition to meeting the requirements of parts 9530.6405 to 9530.6490, license holders specializing in the treatment of persons with substance use disorder and mental health problems must:

- A. demonstrate that staffing levels are appropriate for treating clients with substance use disorder and mental health problems, and that there is adequate staff with mental health training;
- B. have continuing access to a medical provider with appropriate expertise in prescribing psychotropic medications;
- C. have a mental health professional available for staff supervision and consultation;
- D. determine group size, structure, and content with consideration for the special needs of those with substance use disorder and mental health disorders;
- E. have documentation of active interventions to stabilize mental health symptoms present in treatment plans and progress notes;
- F. have continuing documentation of collaboration with continuing care mental health providers, and involvement of those providers in treatment planning meetings;
- G. have available program materials adapted to individuals with mental health problems;
- H. have policies that provide flexibility for clients who may lapse in treatment or may have difficulty adhering to established treatment rules as a result of a mental illness, with the goal of helping clients successfully complete treatment; and
- I. have individual psychotherapy and case management available during the treatment process.

9530.6500 PROGRAMS SERVING INTRAVENOUS DRUG ABUSERS.

Subpart 1. **Additional requirements.** In addition to the requirements of parts 9530.6405 to 9530.6505, programs serving intravenous drug abusers must comply with the requirements of this part.

Subp. 2. **Capacity management and waiting list system compliance.** A program serving intravenous drug abusers must notify the department within seven days of when the program reaches both 90 and 100 percent of the program's capacity to care for clients. Each week, the program must report its capacity, current enrolled dosing clients, and any waiting list. A program reporting 90 percent of capacity must also notify the department when its census has increased or decreased from the 90 percent level.

Subp. 3. **Waiting list.** A program serving intravenous drug abusers must have a waiting list system. Each person seeking admission must be placed on the waiting list if the person cannot be admitted within 14 days of the date of application, unless the applicant is assessed by the program and found not to be eligible for admission according to parts 9530.6405 to 9530.6505, and Code of Federal Regulations, title 42, part 1, subchapter A, section 8.12(e), and Code of Federal Regulations, title 45, parts 160 to 164. The waiting list must assign a unique patient identifier for each intravenous drug abuser seeking treatment while awaiting admission. An applicant on a waiting list who receives no services under part 9530.6430, subpart 1, must not be considered a "client" as defined in part 9530.6405, subpart 8.

Subp. 4. **Client referral.** Programs serving intravenous drug abusers must consult the capacity management system so that persons on waiting lists are admitted at the earliest time to a program providing appropriate treatment within a reasonable geographic area. If the patient has been referred through a public payment system and if the program is not able to serve the client within 14 days of the date of application for admission, the program must contact and inform the referring agency of any available treatment capacity listed in the state capacity management system.

Subp. 5. **Outreach.** Programs serving intravenous drug abusers must carry out activities to encourage individuals in need of treatment to undergo treatment. The program's outreach model must:

- A. select, train, and supervise outreach workers;
- B. contact, communicate, and follow up with high risk substance abusers, their associates, and neighborhood residents within the constraints of federal and state confidentiality requirements, including Code of Federal Regulations, title 42, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;
- C. promote awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV; and
- D. recommend steps that can be taken to ensure that HIV transmission does not occur.

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Subp. 6. **Central registry.** Programs serving intravenous drug abusers must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The client's failure to provide the information will prohibit involvement in an opiate treatment program. The information submitted must include the client's:

- A. full name and all aliases;
- B. date of admission;
- C. date of birth;
- D. Social Security number or INS number, if any;
- E. enrollment status in other current or last known opiate treatment programs;
- F. government-issued photo-identification card number; and
- G. driver's license number, if any.

The information in items A to G must be submitted in a format prescribed by the commissioner, with the original kept in the client's chart, whenever a client is accepted for treatment, the client's type or dosage of a drug is changed, or the client's treatment is interrupted, resumed, or terminated.

9530.6505 REQUIREMENTS FOR LICENSED RESIDENTIAL TREATMENT.

Subpart 1. **Applicability.** A license holder who provides supervised room and board at the licensed program site as a treatment component is defined as a residential program according to Minnesota Statutes, section 245A.02, subdivision 14, and is subject to this part.

Subp. 2. **Visitors.** Clients must be allowed to receive visitors at times prescribed by the license holder. The license holder must set and post a notice of visiting rules and hours, including both day and evening times. A client's right to receive visitors other than a personal physician, religious advisor, county case manager, parole or probation officer, or attorney may be subject to visiting hours established by the license holder for all clients. The treatment director or designee may impose limitations as necessary for the welfare of a client provided that limitations and the reasons for them are documented in the client's file. Clients must be allowed to receive visits at all reasonable times from their personal physicians, religious advisors, county case managers, parole or probation officers, and attorneys.

Subp. 3. **Client property management.** A license holder who provides room and board and treatment services to clients in the same facility, and any license holder that accepts client property must meet the requirements in Minnesota Statutes, section 245A.04, subdivision 13, for handling resident funds and property. In the course of client property management, license holders:

A. may establish policies regarding the use of personal property to assure that treatment activities and the rights of other patients are not infringed;

B. may take temporary custody of property for violation of facility policies;

C. must retain the client's property for a minimum of seven days after discharge if the client does not reclaim property upon service termination, or for a minimum of 30 days if the client does not reclaim property upon service termination and has received room and board services from the license holder; and

D. must return all property held in trust to the client upon service termination regardless of the client's service termination status, except:

(1) drugs, drug paraphernalia, and drug containers that are forfeited under Minnesota Statutes, section 609.5316, must be destroyed by staff or given over to the custody of a local law enforcement agency, according to Code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and Code of Federal Regulations, title 45, parts 160 to 164;

(2) weapons, explosives, and other property which can cause serious harm to self or others must be given over to the custody of a local law enforcement agency, and the client must be notified of the transfer and of the right to reclaim any lawful property transferred; and

(3) medications that have been determined by a physician to be harmful after examining the client, except when the client's personal physician approves the medication for continued use.

Subp. 4. **Health facility license.** A license holder who provides room and board and treatment services in the same facility must have the appropriate license from the Department of Health.

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Subp. 5. **Facility abuse prevention plan.** A license holder must establish and enforce an ongoing facility abuse prevention plan consistent with Minnesota Statutes, sections 245A.65 and 626.557, subdivision 14.

Subp. 6. **Individual abuse prevention plan.** A license holder must prepare an individual abuse prevention plan for each client as specified under Minnesota Statutes, sections 245A.65, subdivision 2, and 626.557, subdivision 14.

Subp. 7. **Health services.** License holders must have written procedures for assessing and monitoring client health, including a standardized data collection tool for collecting health-related information about each client. The policies and procedures must be approved and signed by a registered nurse.

Subp. 8. **Administration of medications.** License holders must meet the administration of medications requirements of part 9530.6435, subpart 3.